Irish Association For Palliative Care
24th Education and Research Seminar

Integration and Innovation across The Lifespan

11TH February 2025

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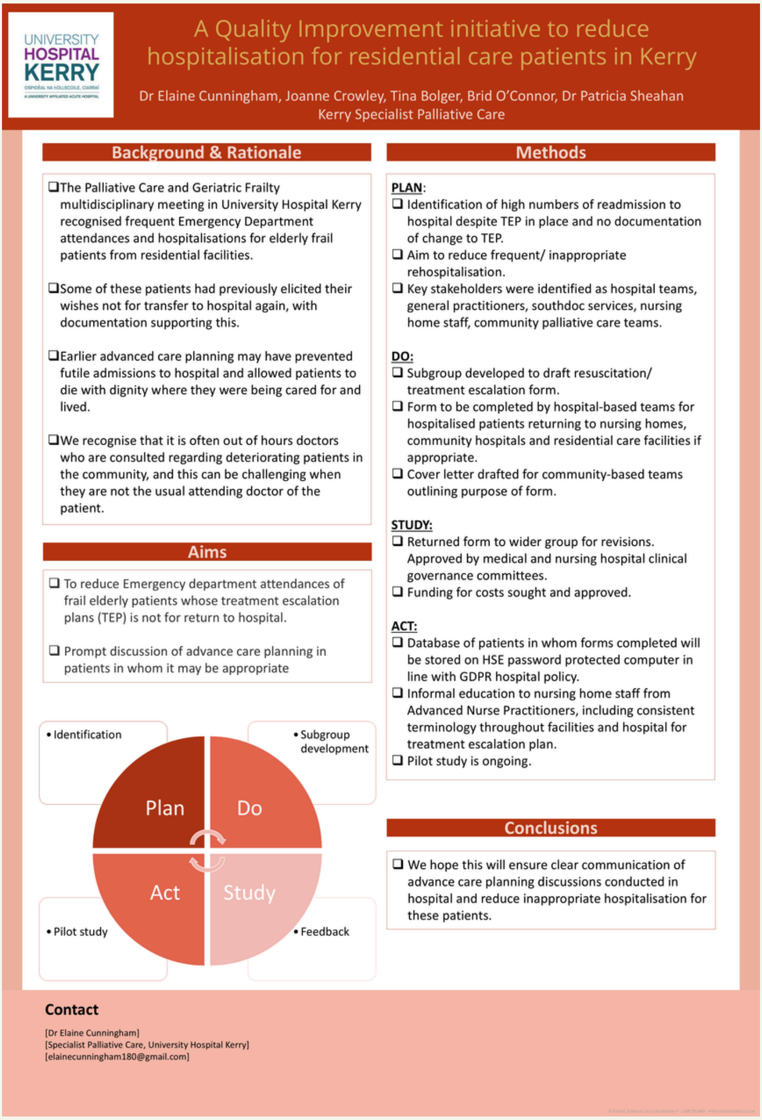
QI Projects



A Quality Improvement initiative to reduce hospitalisation for residential care patients in Kerry

Dr Elaine Cunningham, Joanne Crowley, Tina Bolger, Brid O'Connor, Dr Patricia Sheahan
Kerry Specialist Palliative Care

Background & Rationale

❑ The Palliative Care and Geriatric Frailty multidisciplinary meeting in University Hospital Kerry recognised frequent Emergency Department attendances and hospitalisations for elderly frail patients from residential facilities.

❑ Some of these patients had previously elicited their wishes not for transfer to hospital again, with documentation supporting this.

❑ Earlier advanced care planning may have prevented futile admissions to hospital and allowed patients to die with dignity where they were being cared for and lived.

❑ We recognise that it is often out of hours doctors who are consulted regarding deteriorating patients in the community, and this can be challenging when they are not the usual attending doctor of the patient.

Aims

❑ To reduce Emergency department attendances of frail elderly patients whose treatment escalation plans (TEP) is not for return to hospital.

❑ Prompt discussion of advance care planning in patients in whom it may be appropriate

Methods

PLAN:
❑ Identification of high numbers of readmission to hospital despite TEP in place and no documentation of change to TEP.
❑ Aim to reduce frequent/ inappropriate rehospitalisation.
❑ Key stakeholders were identified as hospital teams, general practitioners, southdoc services, nursing home staff, community palliative care teams.

DO:
❑ Subgroup developed to draft resuscitation/ treatment escalation form.
❑ Form to be completed by hospital-based teams for hospitalised patients returning to nursing homes, community hospitals and residential care facilities if appropriate.
❑ Cover letter drafted for community-based teams outlining purpose of form.

STUDY:
❑ Returned form to wider group for revisions. Approved by medical and nursing hospital clinical governance committees.
❑ Funding for costs sought and approved.

ACT:
❑ Database of patients in whom forms completed will be stored on HSE password protected computer in line with GDPR hospital policy.
❑ Informal education to nursing home staff from Advanced Nurse Practitioners, including consistent terminology throughout facilities and hospital for treatment escalation plan.
❑ Pilot study is ongoing.

Conclusions

❑ We hope this will ensure clear communication of advance care planning discussions conducted in hospital and reduce inappropriate hospitalisation for these patients.

Contact

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Title: A Quality Improvement initiative to reduce hospitalisation for residential care patients in Kerry

Authors: Cunningham, Crowley, Bolger, O'Connor, Sheahan

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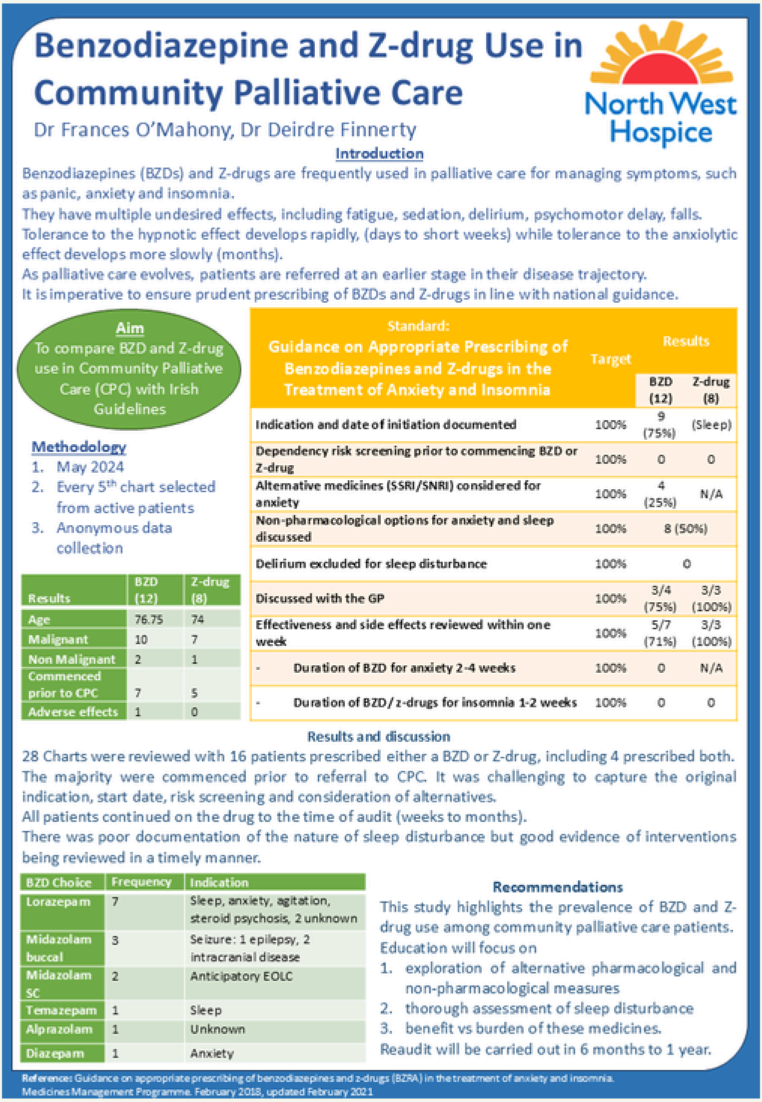

Benzodiazepine and Z-drug Use in Community Palliative Care

Dr Frances O'Mahony, Dr Deirdre Finnerty

North West Hospice

Introduction

Benzodiazepines (BZDs) and Z-drugs are frequently used in palliative care for managing symptoms, such as panic, anxiety and insomnia.

They have multiple undesired effects, including fatigue, sedation, delirium, psychomotor delay, falls.

Tolerance to the hypnotic effect develops rapidly, (days to short weeks) while tolerance to the anxiolytic effect develops more slowly (months).

As palliative care evolves, patients are referred at an earlier stage in their disease trajectory.

It is imperative to ensure prudent prescribing of BZDs and Z-drugs in line with national guidance.

Aim

To compare BZD and Z-drug use in Community Palliative Care (CPC) with Irish Guidelines

Methodology

1. May 2024
2. Every 5th chart selected from active patients
3. Anonymous data collection

Results	BZD (12)	Z-drug (8)
Age	76.75	74
Malignant	10	7
Non Malignant	2	1
Commenced prior to CPC	7	5
Adverse effects	1	0

Standard: Guidance on Appropriate Prescribing of Benzodiazepines and Z-drugs in the Treatment of Anxiety and Insomnia	Target	Results	
		BZD (12)	Z-drug (8)
Indication and date of initiation documented	100%	9 (75%)	(Sleep)
Dependency risk screening prior to commencing BZD or Z-drug	100%	0	0
Alternative medicines (SSRI/SNRI) considered for anxiety	100%	4 (25%)	N/A
Non-pharmacological options for anxiety and sleep discussed	100%	8 (50%)	
Delirium excluded for sleep disturbance	100%	0	
Discussed with the GP	100%	3/4 (75%)	3/3 (100%)
Effectiveness and side effects reviewed within one week	100%	5/7 (71%)	3/3 (100%)
- Duration of BZD for anxiety 2-4 weeks	100%	0	N/A
- Duration of BZD/z-drugs for insomnia 1-2 weeks	100%	0	0

Results and discussion

28 Charts were reviewed with 16 patients prescribed either a BZD or Z-drug, including 4 prescribed both. The majority were commenced prior to referral to CPC. It was challenging to capture the original indication, start date, risk screening and consideration of alternatives.

All patients continued on the drug to the time of audit (weeks to months).

There was poor documentation of the nature of sleep disturbance but good evidence of interventions being reviewed in a timely manner.

BZD Choice	Frequency	Indication
Lorazepam	7	Sleep, anxiety, agitation, steroid psychosis, 2 unknown
Midazolam buccal	3	Seizure: 1 epilepsy, 2 intracranial disease
Midazolam SC	2	Anticipatory EOLC
Temazepam	1	Sleep
Alprazolam	1	Unknown
Diazepam	1	Anxiety

Recommendations

This study highlights the prevalence of BZD and Z-drug use among community palliative care patients.

Education will focus on

1. exploration of alternative pharmacological and non-pharmacological measures
2. thorough assessment of sleep disturbance
3. benefit vs burden of these medicines.

Reaudit will be carried out in 6 months to 1 year.

Reference: Guidance on appropriate prescribing of benzodiazepines and z-drugs (BZRA) in the treatment of anxiety and insomnia. Medicines Management Programme. February 2018, updated February 2021

Title: Review of Benzodiazepine and Z-Drug Use in Community Palliative Care

Authors: O'Mahony, Finnerty

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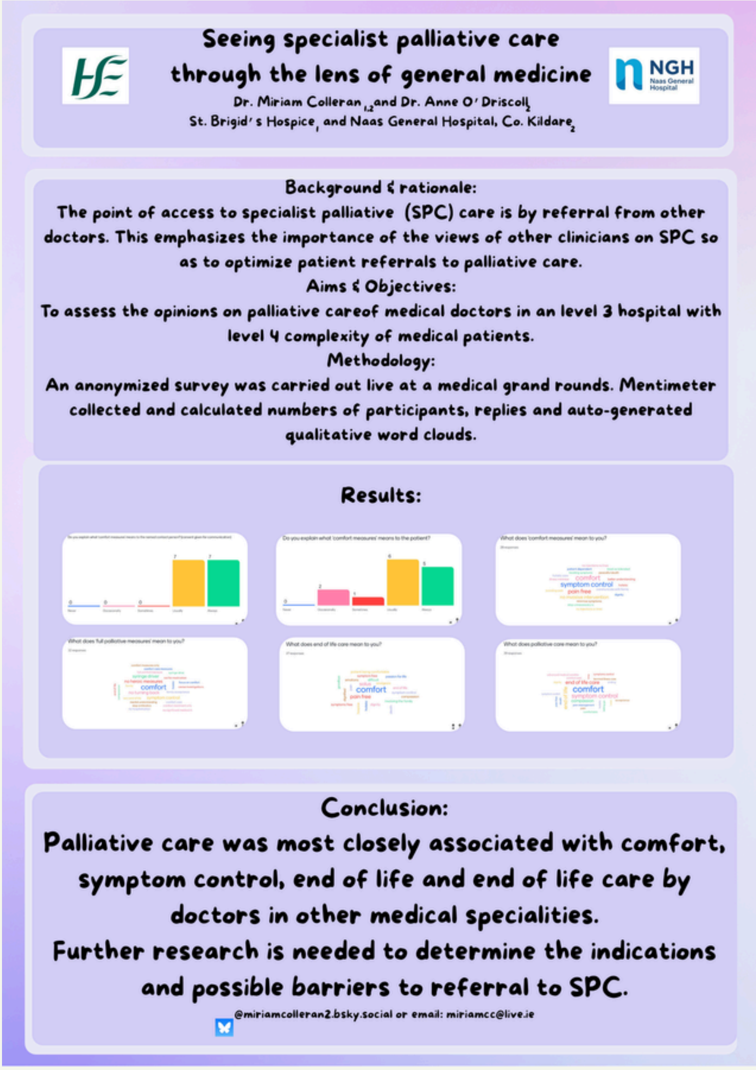

Seeing specialist palliative care through the lens of general medicine

Dr. Miriam Colleran [1,2] and Dr. Anne O' Driscoll [2]
St. Brigid' s Hospice [1] and Naas General Hospital, Co. Kildare [2]

Background & rationale:

The point of access to specialist palliative (SPC) care is by referral from other doctors. This emphasizes the importance of the views of other clinicians on SPC so as to optimize patient referrals to palliative care.

Aims & Objectives:

To assess the opinions on palliative careof medical doctors in an level 3 hospital with level 4 complexity of medical patients.

Methodology:

An anonymized survey was carried out live at a medical grand rounds. Mentimeter collected and calculated numbers of participants, replies and auto-generated qualitative word clouds.

Results:

Conclusion:

Palliative care was most closely associated with comfort, symptom control, end of life and end of life care by doctors in other medical specialities.

Further research is needed to determine the indications and possible barriers to referral to SPC.

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Title: Seeing specialist palliative care through the lens of general medicine

Authors: Colleran, O’Driscoll

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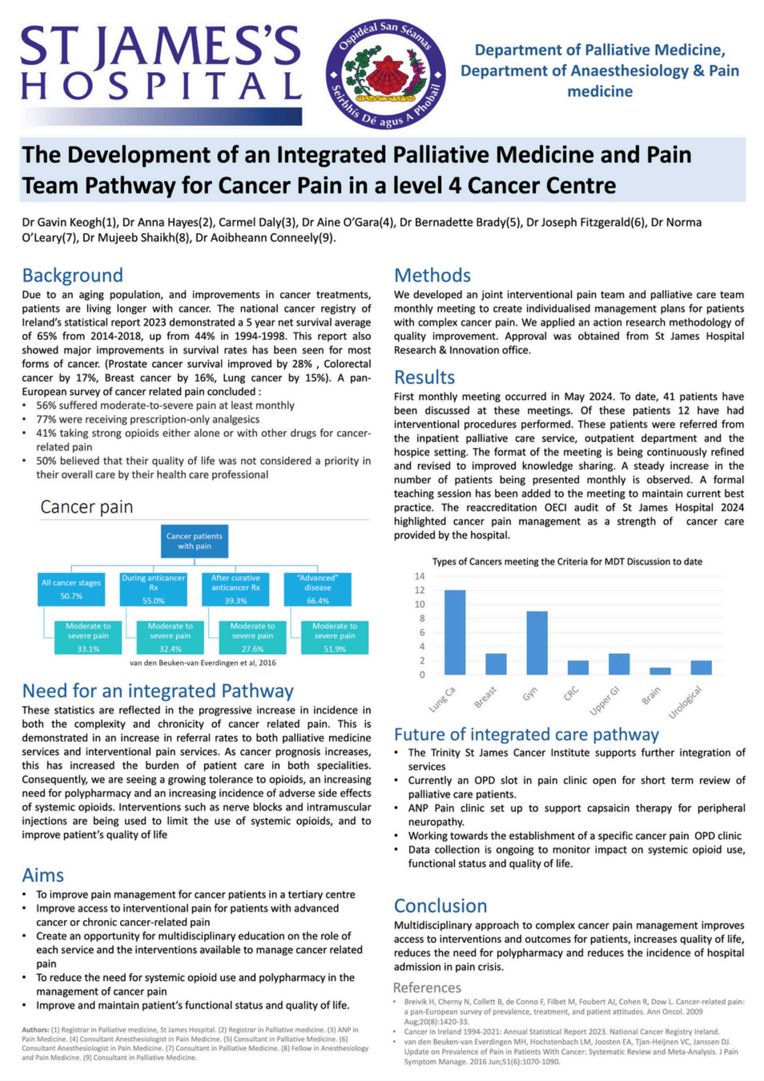

ST JAMES'S HOSPITAL

Ospidéal San Séamas
Seirbhís Dé agus A Phobail

Department of Palliative Medicine, Department of Anaesthesiology & Pain medicine

The Development of an Integrated Palliative Medicine and Pain Team Pathway for Cancer Pain in a level 4 Cancer Centre

Dr Gavin Keogh(1), Dr Anna Hayes(2), Carmel Daly(3), Dr Aine O'Gara(4), Dr Bernadette Brady(5), Dr Joseph Fitzgerald(6), Dr Norma O'Leary(7), Dr Mujeeb Shaikh(8), Dr Aoibheann Conneely(9).

Background

Due to an aging population, and improvements in cancer treatments, patients are living longer with cancer. The national cancer registry of Ireland's statistical report 2023 demonstrated a 5 year net survival average of 65% from 2014-2018, up from 44% in 1994-1998. This report also showed major improvements in survival rates has been seen for most forms of cancer. (Prostate cancer survival improved by 28% , Colorectal cancer by 17%, Breast cancer by 16%, Lung cancer by 15%). A pan-European survey of cancer related pain concluded :

- 56% suffered moderate-to-severe pain at least monthly
- 77% were receiving prescription-only analgesics
- 41% taking strong opioids either alone or with other drugs for cancer-related pain
- 50% believed that their quality of life was not considered a priority in their overall care by their health care professional

Cancer pain

Cancer patients with pain

All cancer stages 50.7%
Moderate to severe pain 33.1%

During anticancer Rx 55.0%
Moderate to severe pain 32.4%

After curative anticancer Rx 39.3%
Moderate to severe pain 27.6%

"Advanced" disease 66.4%
Moderate to severe pain 51.9%

van den Beuken-van Everdingen et al, 2016

Need for an integrated Pathway

These statistics are reflected in the progressive increase in incidence in both the complexity and chronicity of cancer related pain. This is demonstrated in an increase in referral rates to both palliative medicine services and interventional pain services. As cancer prognosis increases, this has increased the burden of patient care in both specialities. Consequently, we are seeing a growing tolerance to opioids, an increasing need for polypharmacy and an increasing incidence of adverse side effects of systemic opioids. Interventions such as nerve blocks and intramuscular injections are being used to limit the use of systemic opioids, and to improve patient's quality of life

Aims

- To improve pain management for cancer patients in a tertiary centre
- Improve access to interventional pain for patients with advanced cancer or chronic cancer-related pain
- Create an opportunity for multidisciplinary education on the role of each service and the interventions available to manage cancer related pain
- To reduce the need for systemic opioid use and polypharmacy in the management of cancer pain
- Improve and maintain patient's functional status and quality of life.

Authors: (1) Registrar in Palliative medicine, St James Hospital. (2) Registrar in Palliative medicine. (3) ANP in Pain Medicine. (4) Consultant Anesthesiologist in Pain Medicine. (5) Consultant in Palliative Medicine. (6) Consultant Anesthesiologist in Pain Medicine. (7) Consultant in Palliative Medicine. (8) Fellow in Anesthesiology and Pain Medicine. (9) Consultant in Palliative Medicine.

Methods

We developed an joint interventional pain team and palliative care team monthly meeting to create individualised management plans for patients with complex cancer pain. We applied an action research methodology of quality improvement. Approval was obtained from St James Hospital Research & Innovation office.

Results

First monthly meeting occurred in May 2024. To date, 41 patients have been discussed at these meetings. Of these patients 12 have had interventional procedures performed. These patients were referred from the inpatient palliative care service, outpatient department and the hospice setting. The format of the meeting is being continuously refined and revised to improved knowledge sharing. A steady increase in the number of patients being presented monthly is observed. A formal teaching session has been added to the meeting to maintain current best practice. The reaccreditation OECI audit of St James Hospital 2024 highlighted cancer pain management as a strength of cancer care provided by the hospital.

Types of Cancers meeting the Criteria for MDT Discussion to date

Future of integrated care pathway

- The Trinity St James Cancer Institute supports further integration of services
- Currently an OPD slot in pain clinic open for short term review of palliative care patients.
- ANP Pain clinic set up to support capsaicin therapy for peripheral neuropathy.
- Working towards the establishment of a specific cancer pain OPD clinic
- Data collection is ongoing to monitor impact on systemic opioid use, functional status and quality of life.

Conclusion

Multidisciplinary approach to complex cancer pain management improves access to interventions and outcomes for patients, increases quality of life, reduces the need for polypharmacy and reduces the incidence of hospital admission in pain crisis.

References

- Breivik H, Cherny N, Collett B, de Conno F, Filbet M, Foubert AJ, Cohen R, Dow L. Cancer-related pain: a pan-European survey of prevalence, treatment, and patient attitudes. Ann Oncol. 2009 Aug;20(8):1420-33.
- Cancer in Ireland 1994-2021: Annual Statistical Report 2023. National Cancer Registry Ireland.
- van den Beuken-van Everdingen MH, Hochstenbach LM, Joosten EA, Tjan-Heijnen VC, Janssen DJ. Update on Prevalence of Pain in Patients With Cancer: Systematic Review and Meta-Analysis. J Pain Symptom Manage. 2016 Jun;51(6):1070-1090.

Title: The Development of an Integrated Palliative Medicine and Pain Team Pathway

Authors: Keogh, Hayes, Daly, Brady, O'Leary, O'Gara, Fitzgerald, Shaikh, Conneely

QI Projects

Specialist palliative care and persons with intellectual disabilities - a practice review

Dr. Miriam Colleran[1,2] and Dr. Barbara Sheehy-Skeffington[1]
St. Brigid's Hospice[1] and Naas General Hospital, Co. Kildare[2]

Background & rationale:

To explore the use of a specialist palliative care (SPC) service by patients with intellectual disabilities (IDs).

Aims & Objectives:

he purpose of this practice review is to assess the indications for, patient numbers, use and outcomes of care for adults with IDs referred to a SPC service over a 5- year period from November 2018 to 2023 inclusive.

Methodology:

A retrospective review of the manual register of persons referred to a SPC service was carried out by recorded diagnoses, address of local ID services and clinican recall of past patients was also used as a prompt to add identification of patients to assess eligibility for inclusion. This may have under-identified patients. Service utilisation aspects considered included the frequency of home visits by SPC clinicians and the frequency of hospice admission.

	Results:	
patients referred: 20 2 were discharged and e-referred	10 women 8 men	age range: 19- 86 years
patients' diagnoses included: cancer/ likely malignancy (4) cognitive decline / dementia (5)	phonecalls per patient range: 02 - 48	home visits per patient range: 0 - 55
place of dying: community (14) different hospice (1)	community includes institution of intellectual disabilities service or supported accommodation	

Conclusion:

The predominance of the community as the place of death for these patients is noteworthy. Further research is necessary to optimise evidence-informed SPC for persons with intellectual disabilities.

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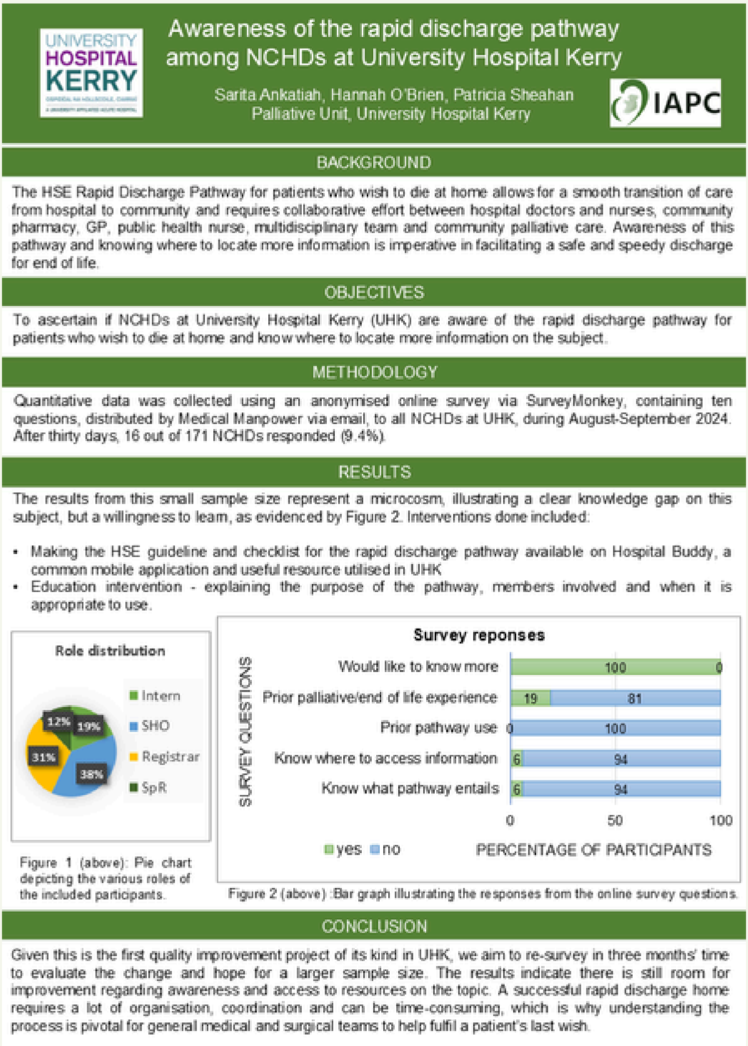
Title: Specialist palliative care and persons with intellectual disabilities – a practice review

Authors: Colleran, Sheehy-Skeffington

QI Projects



Awareness of the rapid discharge pathway among NCHDs at University Hospital Kerry

Sarita Ankatiah, Hannah O'Brien, Patricia Sheahan
Palliative Unit, University Hospital Kerry

BACKGROUND

The HSE Rapid Discharge Pathway for patients who wish to die at home allows for a smooth transition of care from hospital to community and requires collaborative effort between hospital doctors and nurses, community pharmacy, GP, public health nurse, multidisciplinary team and community palliative care. Awareness of this pathway and knowing where to locate more information is imperative in facilitating a safe and speedy discharge for end of life.

OBJECTIVES

To ascertain if NCHDs at University Hospital Kerry (UHK) are aware of the rapid discharge pathway for patients who wish to die at home and know where to locate more information on the subject.

METHODOLOGY

Quantitative data was collected using an anonymised online survey via SurveyMonkey, containing ten questions, distributed by Medical Manpower via email, to all NCHDs at UHK, during August-September 2024. After thirty days, 16 out of 171 NCHDs responded (9.4%).

RESULTS

The results from this small sample size represent a microcosm, illustrating a clear knowledge gap on this subject, but a willingness to learn, as evidenced by Figure 2. Interventions done included:

- Making the HSE guideline and checklist for the rapid discharge pathway available on Hospital Buddy, a common mobile application and useful resource utilised in UHK
- Education intervention - explaining the purpose of the pathway, members involved and when it is appropriate to use.

Figure 1 (above): Pie chart depicting the various roles of the included participants.

Figure 2 (above) :Bar graph illustrating the responses from the online survey questions.

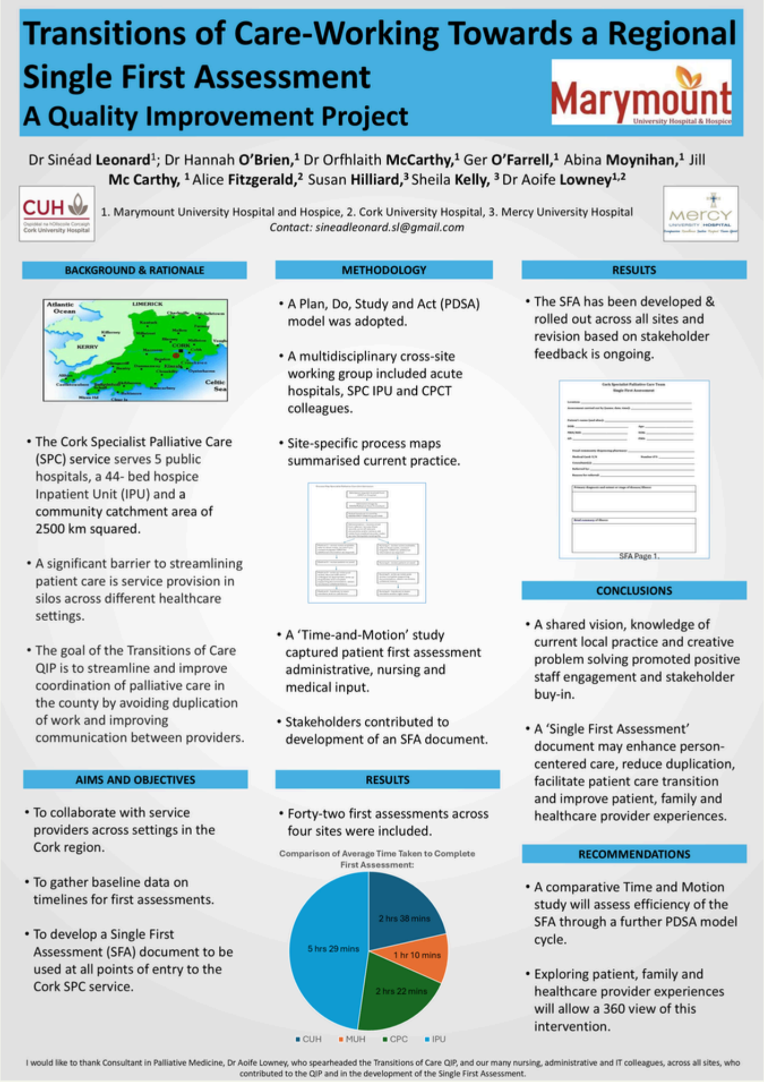
CONCLUSION

Given this is the first quality improvement project of its kind in UHK, we aim to re-survey in three months' time to evaluate the change and hope for a larger sample size. The results indicate there is still room for improvement regarding awareness and access to resources on the topic. A successful rapid discharge home requires a lot of organisation, coordination and can be time-consuming, which is why understanding the process is pivotal for general medical and surgical teams to help fulfil a patient's last wish.

Title: Awareness of the Rapid Discharge Pathway among NCHDs at University Hospital Kerry

Authors: Ankatiah, O'Brien, Sheahan

QI Projects



Transitions of Care-Working Towards a Regional Single First Assessment
A Quality Improvement Project

Dr Sinéad **Leonard**[1]; Dr Hannah **O'Brien,**[1] Dr Orfhlaith **McCarthy,**[1] Ger **O'Farrell,**[1] Abina **Moynihan,**[1] Jill **Mc Carthy,** [1] Alice **Fitzgerald,**[2] Susan **Hilliard,**[3] Sheila **Kelly,** [3] Dr Aoife **Lowney**[1,2]

1. Marymount University Hospital and Hospice, 2. Cork University Hospital, 3. Mercy University Hospital
Contact: sineadleonard.sl@gmail.com

BACKGROUND & RATIONALE

- The Cork Specialist Palliative Care (SPC) service serves 5 public hospitals, a 44- bed hospice Inpatient Unit (IPU) and a community catchment area of 2500 km squared.
- A significant barrier to streamlining patient care is service provision in silos across different healthcare settings.
- The goal of the Transitions of Care QIP is to streamline and improve coordination of palliative care in the county by avoiding duplication of work and improving communication between providers.

AIMS AND OBJECTIVES

- To collaborate with service providers across settings in the Cork region.
- To gather baseline data on timelines for first assessments.
- To develop a Single First Assessment (SFA) document to be used at all points of entry to the Cork SPC service.

METHODOLOGY

- A Plan, Do, Study and Act (PDSA) model was adopted.
- A multidisciplinary cross-site working group included acute hospitals, SPC IPU and CPCT colleagues.
- Site-specific process maps summarised current practice.
- A 'Time-and-Motion' study captured patient first assessment administrative, nursing and medical input.
- Stakeholders contributed to development of an SFA document.

RESULTS

- Forty-two first assessments across four sites were included.

Comparison of Average Time Taken to Complete First Assessment:

RESULTS

- The SFA has been developed & rolled out across all sites and revision based on stakeholder feedback is ongoing.

SFA Page 1.

CONCLUSIONS

- A shared vision, knowledge of current local practice and creative problem solving promoted positive staff engagement and stakeholder buy-in.
- A 'Single First Assessment' document may enhance person-centered care, reduce duplication, facilitate patient care transition and improve patient, family and healthcare provider experiences.

RECOMMENDATIONS

- A comparative Time and Motion study will assess efficiency of the SFA through a further PDSA model cycle.
- Exploring patient, family and healthcare provider experiences will allow a 360 view of this intervention.

I would like to thank Consultant in Palliative Medicine, Dr Aoife Lowney, who spearheaded the Transitions of Care QIP, and our many nursing, administrative and IT colleagues, across all sites, who contributed to the QIP and in the development of the Single First Assessment.

Title: Transitions of Care – Working towards a regional Single First Assessment

Authors: Leonard, O'Brien, McCarthy, Lowney

QI Projects

Enhancing our understanding of communication between Community Palliative Care and GPs

Background

- Community palliative care involves GPs working closely with specialist teams to provide holistic care for patients.
- Effective communication encourages teamwork, prevents errors and enhances patient safety

Question

- How effective are current communication practices?
- Can they be improved?
- 2 surveys, 1 to GPs and 1 to the Community Team.

Results

GP

"Keep it brief"
"Medication changes"
"Symptom burden"
"Next review date"
"Please use healthlink"
"Depends on urgency for communication"

CPCT

"Communication is based on urgency"
"When is the best time to contact ? "
"Acknowledge correspondence"
"Meet with local GPs"

Conclusions

- The majority believe communication can be improved.
- Delays in prescribing are common, but medication errors are infrequent.
- Urgency must be considered when choosing the communication option.
- **Template may improve communication**

Template

Name
DOB
Diagnosis
Date of Visit

Active issues

Recommendations

Changes to medication

Date of next visit

Please acknowledge receipt of this email.

Yours Sincerely

Contact No
Email Address

Title: Improving communication between GPs and the Community palliative care team

Authors: Skehan, McMahon

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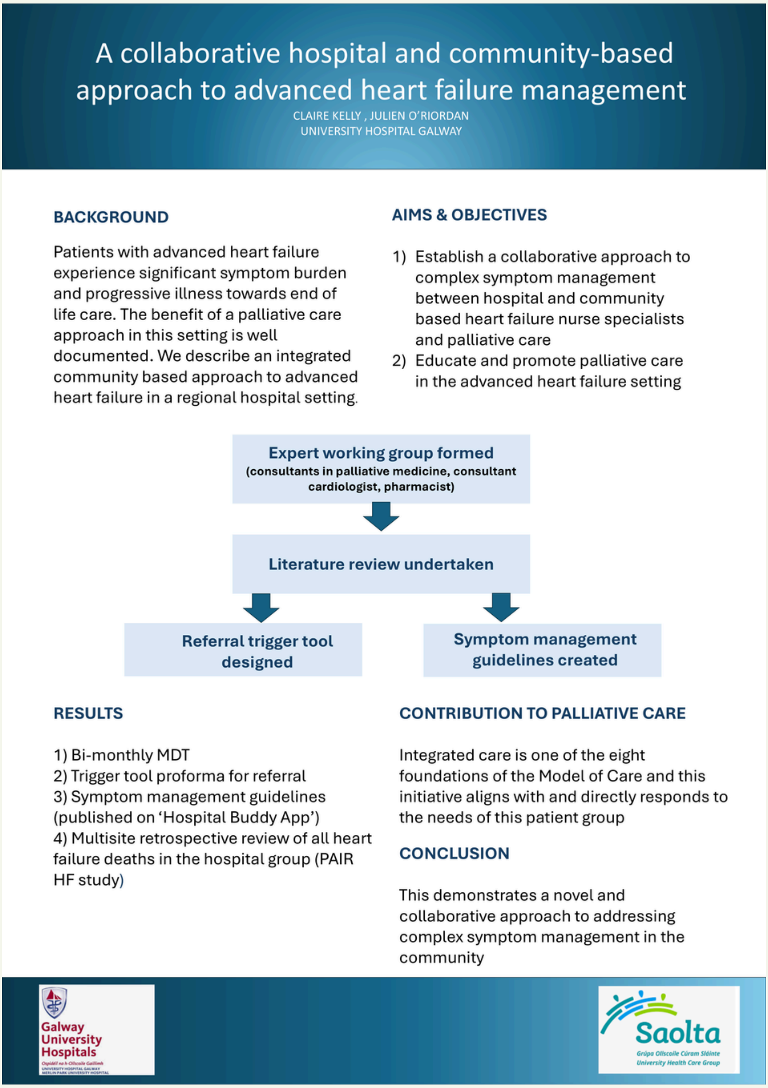

A collaborative hospital and community-based approach to advanced heart failure management

CLAIRE KELLY , JULIEN O'RIORDAN
UNIVERSITY HOSPITAL GALWAY

BACKGROUND

Patients with advanced heart failure experience significant symptom burden and progressive illness towards end of life care. The benefit of a palliative care approach in this setting is well documented. We describe an integrated community based approach to advanced heart failure in a regional hospital setting.

AIMS & OBJECTIVES

1) Establish a collaborative approach to complex symptom management between hospital and community based heart failure nurse specialists and palliative care
2) Educate and promote palliative care in the advanced heart failure setting

Expert working group formed
(consultants in palliative medicine, consultant cardiologist, pharmacist)

Literature review undertaken

Referral trigger tool designed

Symptom management guidelines created

RESULTS

1) Bi-monthly MDT
2) Trigger tool proforma for referral
3) Symptom management guidelines (published on 'Hospital Buddy App')
4) Multisite retrospective review of all heart failure deaths in the hospital group (PAIR HF study)

CONTRIBUTION TO PALLIATIVE CARE

Integrated care is one of the eight foundations of the Model of Care and this initiative aligns with and directly responds to the needs of this patient group

CONCLUSION

This demonstrates a novel and collaborative approach to addressing complex symptom management in the community

Title: A collaborative hospital and community based approach to advanced heart failure management

Authors: Kelly, O'Riordan

QI Projects

The Development and Implementation of a Palliative Care Resource Folder in Naas General Hospital: A Quality Improvement Project.

L. Rogers[1], L. White1[1], M. Colleran[1], C. Kinsella[1], E. Harris[1], K. O' Malley[1], B. Alias[1], E. Kohn[1] and M. Lalor[1]

[1] Naas General Hospital, Naas, Co Kildare.

Background

Palliative care is an approach to care focused on reducing and relieving symptoms of advanced progressive illnesses. Palliative care provision is the responsibility of the whole healthcare team and uses a team approach in planning and providing care tailored to meet the individual needs of the person and their family or loved ones. Palliative care incorporates physical, symptom control, psychological or social distress, end-of-life care and future or advanced care planning as patients transitior

Table 1: Palliative Care Structures

The Quality Standards for End of Life Care in acute hospitals endorse the importance of hospitals providing education and training to Hospital staff to enhance EOL care. The Survey of Bereaved relatives VOICES MaJam Report (2017) and a National Clinical Programme for Palliative Care review (2019) identified the lack of knowledge & skills in palliative care provision as a gaps in the provision of palliative care education

Aim

The aim of this Quality Improvement (QI) project is to standardise and guide the palliative care practices of staff in an acute hospital setting, which in turn would enhance evidence-based person-centred care for patients with palliative care needs during their illness trajectory in an acute hospital setting.

Methodology

This QI project was aligned with the 'Framework for Improving Quality in our Health Service' (HSE 2016) and the HSE Adult Palliative Care Services, Model of Care for Ireland. The Model for Improvement was used. A stakeholder analysis was conducted to establish a working committee, when established met bi-monthly. A root cause analysis was performed using a fishbone diagram identified a lack of standardised evidence based palliative care information for acute hospital staff. The Irish Hospice Foundation and the Friends of Naas General Hospital financially supported this project.

Intervention & Results

A series of evidence based Palliative Care Factsheets were developed to improve the delivery of palliative care intervention in an acute hospital setting. These factsheets were collated into a 'Palliative Care Resource Folder' and launched locally in March 2023 using:

- Informal Ward-based education over a 6-week period
- Information Stands (Hospital Staff and the public)
- Social Media (Twitte)

The sustainability of the QI was enhanced by:

- Incorporating of the folder in all Palliative Education (for orientation programmes, in-service days, refresher days)
- Using it as a Point of Care Palliative-based educational resource

Multiple mediums were used to access palliative folders:

- ○ Hard copy in all clinical areas
- ○ Soft copy via Qpulse
- ○ QR Codes on each factsheet

Reach, Scalability and Ripple Effect

- •Ongoing Ward-based Education
- •Incorporated the Resource folders into Palliative Care Study Days
- •Audit compliance with Palliative Care practices following the launch of the QI Project
- •Development & implementation of additional factsheets
- •Service user feedback

References:
National Clinical Programme for Palliative Care (2019) Adult Palliative Care Services, Model of Care for Ireland.
O'Colmin *et al* (2017) Survey of Bereaved Relatives: VOICES MaJam. Dublin: Mater Misericordiae University Hospital and St James Hospital.

Title: The Development and Implementation of a Palliative Care Resource Folder in Naas General Hospital: A Quality Improvement Project

Authors: Rogers

QI Projects

Level 1 palliative care across the continuum: Enabling conversations and supporting quality care

First and Co-Authors: Siobhán Murphy, Orla Keegan, Ann Marie Murphy, Valerie Smith
Organisation: Irish Hospice Foundation
Contact: Siobhán Murphy | 087 093 8222 | siobhan.murphy@hospicefoundation.ie

Introduction/background

In the final six months of life, people frequently have to navigate multiple care settings. This is a critical time to identify and discuss end-of-life wishes and co-ordinate care to achieve them. The National End of Life Survey 2024 (NELS)[1] highlighted challenges faced, such as poor co-ordination of care, lack of discussion on end-of-life needs and wishes, and limited bereavement support.

Irish Hospice Foundation (IHF) aims to support people to die and grieve well through a number of aligned national initiatives. We work within a wider healthcare system, and support generalist (palliative) care, working alongside patients, specialist care providers and others in a complementary and supportive way.

Aims and objectives

IHF values of integrity, courage, compassion, respect and dignity are fundamental to our programmes which aim to support integration of quality palliative care by:

- Empowering staff to deliver person-centred level 1 palliative care.
- Enabling conversations about dying, death and bereavement, and supporting advance care planning.
- Supporting people through bereavement and grief.

Approach

IHF programmes are aligned with the Palliative Care Competency Framework at level 1[2] and recognise and support the interdependence between specialist and non-specialist services. These programmes include:

1. Think Ahead, an advance care planning tool
2. Caru, a quality improvement continuous learning programme in nursing homes
3. Dying Well at Home, supporting people dying at home
4. Bereavement support, through our Bereavement Support Line and bereavement networks
5. Hospice Friendly Hospitals, improving end-of-life care in acute hospitals
6. Arts and Cultural Engagement, exploring death and grief through collaborations with artists and cultural organisations in various settings

Informed by internal and external research, IHF has identified areas of need in end-of-life and bereavement support and devised and funded innovations, established proof of concept, and identified opportunities for mainstreaming programmes across health and social care settings. We will continue to support and adapt this approach in line with recommendations in the National Palliative Care Policy[3].

Conclusion/recommendations

The integrated approach taken by IHF is beneficial in responding to the needs of individuals receiving care in multiple settings in the final stage of their life because it:

- Supports culture change by encouraging conversations around dying, death and bereavement in settings where people are regularly faced with these experiences.
- Increases understanding and appropriate responses to the expressed desire of people to have these conversations.
- Ensures staff across these settings receive high quality training (at level 1) to support them.
- Generates supportive, practical and accessible resources.

Irish Hospice Foundation
To die and grieve well wherever the place

References:
[1] https://yourexperience.ie/wp-content/uploads/2024/04/NELS-National-Report-2023.pdf
[2] https://www.hse.ie/eng/about/who/cspd/ncps/palliative-care/moc/ncp-palliative-care-model-of-care- 24-04-02191.pdf
[3] https://www.gov.ie/en/publication/611ad-national-adult-palliative-care-policy/

Title: Integrating level 1 palliative care wherever the place: Enabling conversations and supporting personalised care wishes

Authors: Murphy, Keegan, Murphy, Smith, Fullerton

QI Projects

A Cross-Sectional Examination of Extrapyramidal Side-Effects (EPSE) in a Specialist Palliative Medicine Inpatient Unit

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Marymount
University Hospital & Hospice

Background:

- ➢EPSE are serious side effects caused by anti-psychotics and other medications
- ➢A core principle of palliative care involves optimising quality of life
- ➢If side-effects of medications are burdensome it is imperative that we address this issue
- ➢There are a number of ways in which EPSE present or manifest, namely, dystonia, pseudo-parkinsonism, akathesia and tardive dyskinesia
- ➢EPSE are not routinely screened for in hospice settings
- ➢Barnes Akathesia Rating Scale (BARS) is a rating scale for drug-induced akathesia[1]

- ➢The Modified Simpson-Angus Scale (MSAS) is used in rating pseudo-parkinsonism and allows for a "not rateable scale" if one is unable to assess an element of the scale[2]

Aim:

- ➢The aim of the study was to determine and describe the burden of extrapyramidal side-effects (EPSE) in a specialist inpatient unit

Methods:

Ethical approval was obtained.
Ref: ECM 4 (r) 08/11/16

Inclusion criteria: all consenting patients admitted on the ward on the chosen day & all patients well enough to participate

Participants assessed for EPSE with two validated screening tests; the MSAS and BARS

Additional demographic data was collected by means of a self-developed data collection tool.

The data was anonymised and input into both Microsoft Excel and SPSS IBM Statistics software

Results:

37 Inpatients

21 well enough to consider

16 patients met inclusion criteria

- ➢There were 8 male (50%) and 8 female (50%) participants with a mean age of 72 years
- ➢Median length of admission was 32 days

Figure 1. No. of patients taking regular medications with potential to cause EPSE

- ➢With reference to Martindale's Complete Drug Reference[3] there were 9 regular medications associated with EPSE - amitriptyline, haloperidol, olanzapine, levomepromazine, metoclopramide, fluoxetine, escitalopram, diazepam and bromazepam

Figure 2. Duration of treatment

		MSAS		
Number of EPSE causing medications (n)	Normal (<3)	Minimal degree of movement disorder (3-5)	Clinically significant degree of movement disorder (6-11)	Total (n)
0	n=2 (40%)	n=3 (60%)	0	n=5
1	n=5 (71%)	n=2 (29%)	0	n=7
2	0	n=2 (100%)	0	n=2
3	n=1 (50%)	0	n=1 (50%)	n=2
Total (n)	n=8 (50%)	n=7 (44%)	n=1 (6%)	n=16 (100%)

Table 1. MSAS scores and number of medications associated with EPSE

Figure 3. Barnes Akathesia Rating Scale Scores

- ➢One patient scored 1/5 in BARS
- ➢It was appropriate to examine 2 (12.5%) patients both seated and standing
- ➢Risk factors - 6 patients had one, three had 2 and one patient had 3 risk factors
- ➢3 patients with 1 risk factor and 2 patients with 2 risk factors scored 3-5 with MSAS
- ➢The remaining 4 patients scored <3
- ➢The patient with 3 risk factors scored 6-11 on the MSAS

References:
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3. Martindale – The Complete Drug Reference. Edited by Alison Brayfield. Published by Pharmaceutical Press.

Strengths & Limitations:

- ➢To our knowledge this is the first study to examine EPSE in a palliative medicine inpatient population
- ➢The data was examined using bivariate and multivariate analysis; however, due to small numbers it was not possible to run inferential statistics

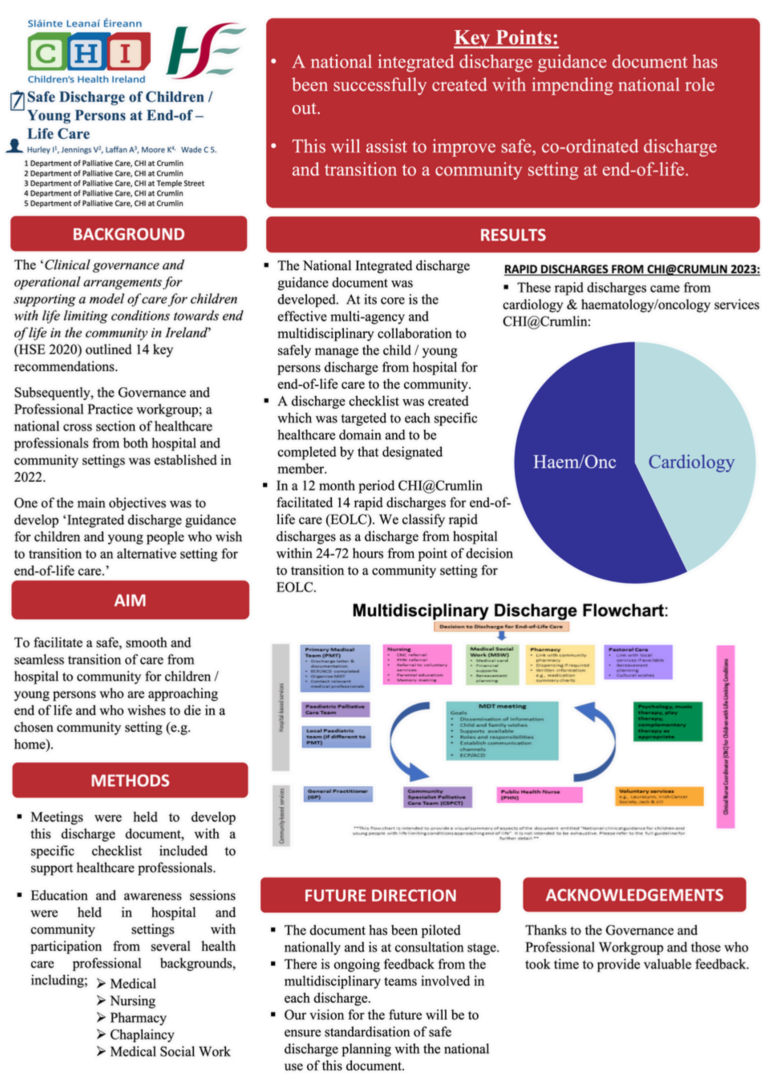
Conclusion:

- ➢50% screened positive for EPSE
- ➢The complete BARS was unsuitable for most participants (87.5%)
- ➢The MSAS while allowing a not-rateable score may underestimate EPSE
- ➢The frailty of an inpatient unit population impacts on applicability of screening tools and may therefore underestimate the burden of the problem in this population
- ➢Development of a population-specific screening tool warrants further investigation

Title: Multidisciplinary quality improvement (QI) project: Avoidance of extrapyramidal side effects of anti-emetrics by studying hospital discharge drugs with advice given on best practice

Authors: Reilly, Keane, Gaffney, Cronin, Mannion, Waldron

QI Projects



Sláinte Leanaí Éireann

CHI

Children's Health Ireland

HSE

Safe Discharge of Children / Young Persons at End-of – Life Care

Hurley I[1], Jennings V[2], Laffan A[3], Moore K[4], Wade C 5.

1 Department of Palliative Care, CHI at Crumlin
2 Department of Palliative Care, CHI at Crumlin
3 Department of Palliative Care, CHI at Temple Street
4 Department of Palliative Care, CHI at Crumlin
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Key Points:

- A national integrated discharge guidance document has been successfully created with impending national role out.
- This will assist to improve safe, co-ordinated discharge and transition to a community setting at end-of-life.

BACKGROUND

The '*Clinical governance and operational arrangements for supporting a model of care for children with life limiting conditions towards end of life in the community in Ireland*' (HSE 2020) outlined 14 key recommendations.

Subsequently, the Governance and Professional Practice workgroup; a national cross section of healthcare professionals from both hospital and community settings was established in 2022.

One of the main objectives was to develop 'Integrated discharge guidance for children and young people who wish to transition to an alternative setting for end-of-life care.'

AIM

To facilitate a safe, smooth and seamless transition of care from hospital to community for children / young persons who are approaching end of life and who wishes to die in a chosen community setting (e.g. home).

METHODS

- Meetings were held to develop this discharge document, with a specific checklist included to support healthcare professionals.
- Education and awareness sessions were held in hospital and community settings with participation from several health care professional backgrounds, including;
    - ➢ Medical
    - ➢ Nursing
    - ➢ Pharmacy
    - ➢ Chaplaincy
    - ➢ Medical Social Work

RESULTS

- The National Integrated discharge guidance document was developed. At its core is the effective multi-agency and multidisciplinary collaboration to safely manage the child / young persons discharge from hospital for end-of-life care to the community.
- A discharge checklist was created which was targeted to each specific healthcare domain and to be completed by that designated member.
- In a 12 month period CHI@Crumlin facilitated 14 rapid discharges for end-of-life care (EOLC). We classify rapid discharges as a discharge from hospital within 24-72 hours from point of decision to transition to a community setting for EOLC.

RAPID DISCHARGES FROM CHI@CRUMLIN 2023:

- These rapid discharges came from cardiology & haematology/oncology services CHI@Crumlin:

Haem/Onc

Cardiology

Multidisciplinary Discharge Flowchart:

Decision to Discharge for End-of-Life Care

Hospital based services

Primary Medical Team (PMT)
- Discharge letter & documentation
- ECP/ACD completed
- Organise MDT
- Contact relevant medical professionals

Nursing
- CNC referral
- PHN referral
- Referral to voluntary services
- Parental education
- Memory making

Medical Social Work (MSW)
- Medical card
- Financial supports
- Bereavement planning

Pharmacy
- Link with community pharmacy
- Dispensing if required
- Written information e.g., medication summary charts

Pastoral Care
- Link with local services if available
- Bereavement planning
- Cultural wishes

Paediatric Palliative Care Team

Local Paediatric team (if different to PMT)

MDT meeting

Goals
- Dissemination of information
- Child and family wishes
- Supports available
- Roles and responsibilities
- Establish communication channels
- ECP/ACD

Psychology, music therapy, play therapy, complementary therapy as appropriate

Community-based services

General Practitioner (GP)

Community Specialist Palliative Care Team (CSPCT)

Public Health Nurse (PHN)

Voluntary services
e.g., LauraLynn, Irish Cancer Society, Jack & Jill

Clinical Nurse Coordinator (CNC) for Children with Life Limiting Conditions

This flow chart is intended to provide a visual summary of aspects of the document entitled "National clinical guidance for children and young people with life limiting conditions approaching end of life". It is not intended to be exhaustive. Please refer to the full guideline for further detail.

FUTURE DIRECTION

- The document has been piloted nationally and is at consultation stage.
- There is ongoing feedback from the multidisciplinary teams involved in each discharge.
- Our vision for the future will be to ensure standardisation of safe discharge planning with the national use of this document.

ACKNOWLEDGEMENTS

Thanks to the Governance and Professional Workgroup and those who took time to provide valuable feedback.

Title: Safe Discharge of Children / Young Persons for End-of Life-Care

Authors: Hurley

Audits

Management of diabetes mellitus at end of life

Dr Niamh Cleary[1], Dr Barry Coffey[1], Dr Faith Cranfield[1]

[1]*St Francis Hospice, Blanchardstown*

Background

The aim of the management of diabetes mellitus at the end of life is to provide an appropriate level of intervention for a patient's stage of illness whilst avoiding diabetic emergencies and symptomatic hypoglycaemia or hyperglycaemia.

This necessitates involvement of patients and their families in setting goals for diabetes management with the objective to maximise quality of life with appropriate levels of treatment and intervention.

Aim

The aim of this audit was to assess adherence to the St Francis Hospice (SFH) diabetes management guidance policy.

Nine standards were derived from this policy.

Methodology

All in-patients in SFH were included on the date of the data collection (n=38).

An audit tool was developed to examine aspects of medication prescribing, blood sugar monitoring and documentation.

Data was collected from patients' healthcare record and medication folders.

Results

Standard:
I. Were non-insulin glucose lowering therapies de-escalated on admission if appropriate?
100% (4/4)
II. Was the de-escalation rationale documented in the medical notes?
50% (2/4)

Standard: Signed glucose monitoring frequency plan
89.5% (17/19)
compliance

Standard: Glucose monitoring form in patient medication folder
92% (35/38)
compliance

Results

Areas of poor compliance:

Standard: Insulin prescribing scale prescribed
42% (8/19) with a blood glucose monitoring form had an insulin sliding scale prescribed.

Standard: In the event of a patient deterioration and shift towards final days of life, medications were appropriately discontinued 100% (1/1) and blood glucose monitoring was reduced 100% (4/4). Documentation of the changes however was only done in *25% (1/4).*

Conclusion

The audit results were disseminated to medical staff at a weekly journal club. Clear documentation of changes at an individual level was encouraged.

A laminated SFH diabetes guidance document was placed in each medication folder for ease of reference for all clinical staff.

The audit tool was incorporated into the Electronic Compliance Auditing Tool. Re-audit was conducted using this new electronic tool.

Results and re-audit of implemented recommendations

Re-audit was conducted (n=19).

Despite the actions designed to improve compliance, only 55.5% (5/9) with a blood glucose monitoring form had an insulin sliding scale prescribed.

Next steps

Add prompts/reminders for admitting doctors in the patient medical record

- Prompt on the 'Glucose Monitoring Form' for doctors to:
  - Prescribe a sliding scale on the reverse side
  - Prescribe rapid-acting insulin 'as required' in the patient's drug Kardex

St. Francis Hospice

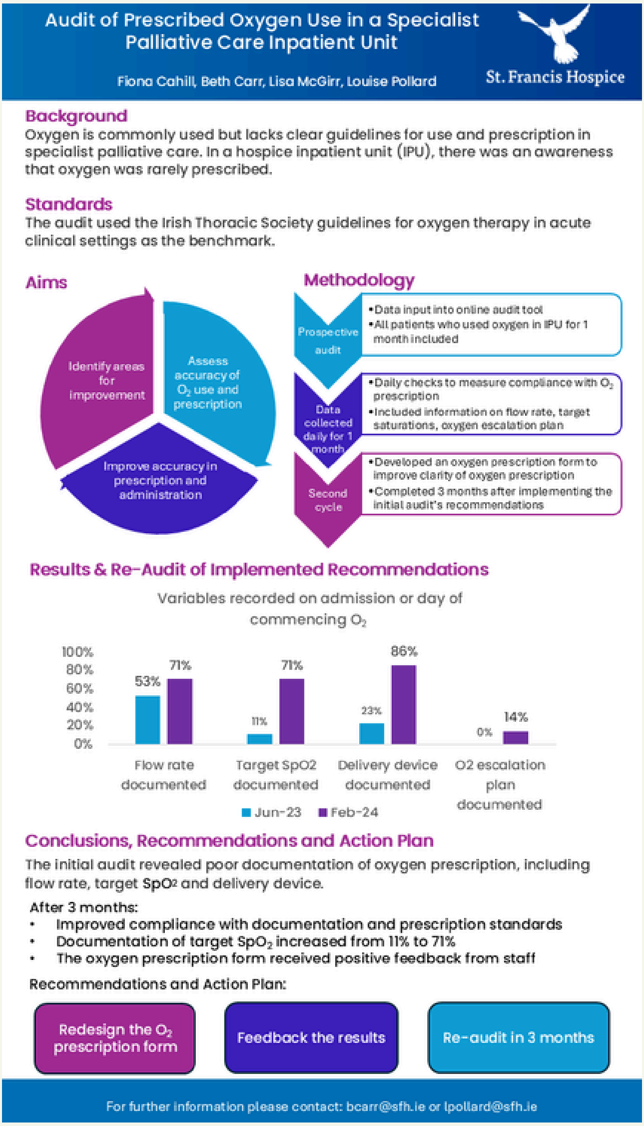
sfh.ie

YouTube video of a patient's experience of PEER

Title: Management of diabetes mellitus at end of life

Authors: Cleary, Cranfield, Coffey

Audits



Audit of Prescribed Oxygen Use in a Specialist Palliative Care Inpatient Unit

Fiona Cahill, Beth Carr, Lisa McGirr, Louise Pollard

St. Francis Hospice

Background

Oxygen is commonly used but lacks clear guidelines for use and prescription in specialist palliative care. In a hospice inpatient unit (IPU), there was an awareness that oxygen was rarely prescribed.

Standards

The audit used the Irish Thoracic Society guidelines for oxygen therapy in acute clinical settings as the benchmark.

Aims

- Identify areas for improvement
- Assess accuracy of O_2 use and prescription
- Improve accuracy in prescription and administration

Methodology

Prospective audit
- Data input into online audit tool
- All patients who used oxygen in IPU for 1 month included

Data collected daily for 1 month
- Daily checks to measure compliance with O_2 prescription
- Included information on flow rate, target saturations, oxygen escalation plan

Second cycle
- Developed an oxygen prescription form to improve clarity of oxygen prescription
- Completed 3 months after implementing the initial audit's recommendations

Results & Re-Audit of Implemented Recommendations

Variables recorded on admission or day of commencing O_2

Conclusions, Recommendations and Action Plan

The initial audit revealed poor documentation of oxygen prescription, including flow rate, target SpO_2 and delivery device.

After 3 months:

- Improved compliance with documentation and prescription standards
- Documentation of target SpO_2 increased from 11% to 71%
- The oxygen prescription form received positive feedback from staff

Recommendations and Action Plan:

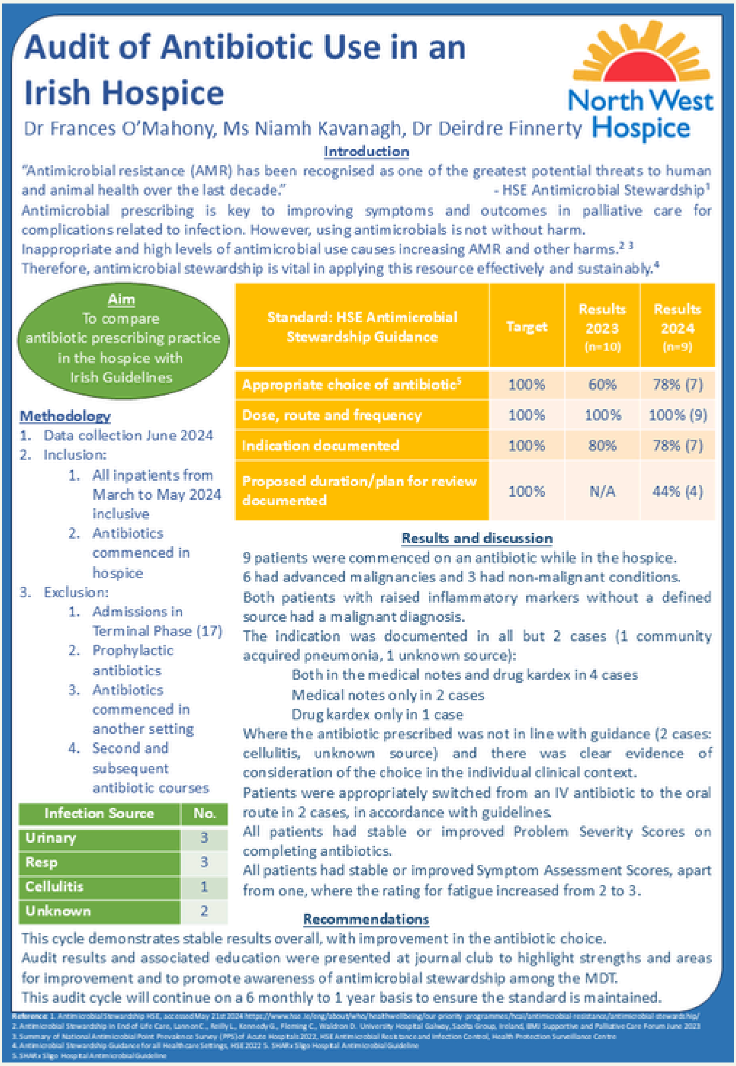
- Redesign the O_2 prescription form
- Feedback the results
- Re-audit in 3 months

For further information please contact: bcarr@sfh.ie or lpollard@sfh.ie

Title: Audit of Prescribed Oxygen Use in a Specialist Palliative Care Inpatient Unit

Authors: Carr, McGirr, Cahill, Pollard

Audits



Audit of Antibiotic Use in an Irish Hospice

Dr Frances O'Mahony, Ms Niamh Kavanagh, Dr Deirdre Finnerty

North West Hospice

Introduction

"Antimicrobial resistance (AMR) has been recognised as one of the greatest potential threats to human and animal health over the last decade." - HSE Antimicrobial Stewardship[1]

Antimicrobial prescribing is key to improving symptoms and outcomes in palliative care for complications related to infection. However, using antimicrobials is not without harm.

Inappropriate and high levels of antimicrobial use causes increasing AMR and other harms.[2 3]

Therefore, antimicrobial stewardship is vital in applying this resource effectively and sustainably.[4]

Aim

To compare antibiotic prescribing practice in the hospice with Irish Guidelines

Standard: HSE Antimicrobial Stewardship Guidance	Target	Results 2023 (n=10)	Results 2024 (n=9)
Appropriate choice of antibiotic[5]	100%	60%	78% (7)
Dose, route and frequency	100%	100%	100% (9)
Indication documented	100%	80%	78% (7)
Proposed duration/plan for review documented	100%	N/A	44% (4)

Methodology

1. Data collection June 2024
2. Inclusion:
    1. All inpatients from March to May 2024 inclusive
    2. Antibiotics commenced in hospice
3. Exclusion:
    1. Admissions in Terminal Phase (17)
    2. Prophylactic antibiotics
    3. Antibiotics commenced in another setting
    4. Second and subsequent antibiotic courses

Infection Source	No.
Urinary	3
Resp	3
Cellulitis	1
Unknown	2

Results and discussion

9 patients were commenced on an antibiotic while in the hospice.

6 had advanced malignancies and 3 had non-malignant conditions.

Both patients with raised inflammatory markers without a defined source had a malignant diagnosis.

The indication was documented in all but 2 cases (1 community acquired pneumonia, 1 unknown source):

Both in the medical notes and drug kardex in 4 cases

Medical notes only in 2 cases

Drug kardex only in 1 case

Where the antibiotic prescribed was not in line with guidance (2 cases: cellulitis, unknown source) and there was clear evidence of consideration of the choice in the individual clinical context.

Patients were appropriately switched from an IV antibiotic to the oral route in 2 cases, in accordance with guidelines.

All patients had stable or improved Problem Severity Scores on completing antibiotics.

All patients had stable or improved Symptom Assessment Scores, apart from one, where the rating for fatigue increased from 2 to 3.

Recommendations

This cycle demonstrates stable results overall, with improvement in the antibiotic choice.

Audit results and associated education were presented at journal club to highlight strengths and areas for improvement and to promote awareness of antimicrobial stewardship among the MDT.

This audit cycle will continue on a 6 monthly to 1 year basis to ensure the standard is maintained.

Reference: 1. Antimicrobial Stewardship HSE, accessed May 21st 2024 https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/antimicrobial-resistance/antimicrobial-stewardship/
2. Antimicrobial Stewardship in End of Life Care, Lannon C., Reilly L., Kennedy G., Fleming C., Waldron D. University Hospital Galway, Saolta Group, Ireland, BMJ Supportive and Palliative Care Forum June 2023
3. Summary of National Antimicrobial Point Prevalence Survey (PPS) of Acute Hospitals 2022, HSE Antimicrobial Resistance and Infection Control, Health Protection Surveillance Centre
4. Antimicrobial Stewardship Guidance for all Healthcare Settings, HSE 2022 5. SHARx Sligo Hospital Antimicrobial Guideline
5. SHARx Sligo Hospital Antimicrobial Guideline

Title: Audit of Antibiotics in a Hospice

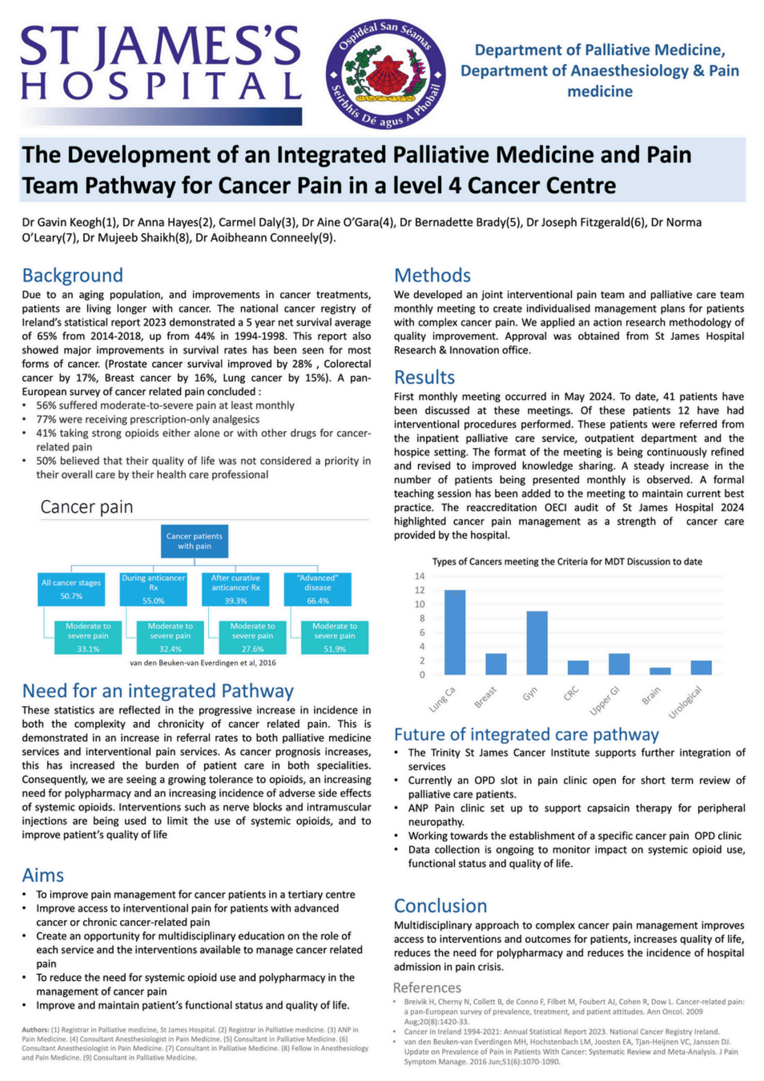
Authors: O'Mahony, Kavanagh, McCarthy, Finnerty

Audits

Title: Audit of Completion of Out-of-Hours Email Prescriptions

Authors: Azhar, Kavanagh, Leyden, Josina, Finnerty, Cleminson, Bogan

Audits



ST JAMES'S HOSPITAL

Ospidéal San Séamas

Seirbhís Dé agus A Phobail

Department of Palliative Medicine, Department of Anaesthesiology & Pain medicine

The Development of an Integrated Palliative Medicine and Pain Team Pathway for Cancer Pain in a level 4 Cancer Centre

Dr Gavin Keogh(1), Dr Anna Hayes(2), Carmel Daly(3), Dr Aine O'Gara(4), Dr Bernadette Brady(5), Dr Joseph Fitzgerald(6), Dr Norma O'Leary(7), Dr Mujeeb Shaikh(8), Dr Aoibheann Conneely(9).

Background

Due to an aging population, and improvements in cancer treatments, patients are living longer with cancer. The national cancer registry of Ireland's statistical report 2023 demonstrated a 5 year net survival average of 65% from 2014-2018, up from 44% in 1994-1998. This report also showed major improvements in survival rates has been seen for most forms of cancer. (Prostate cancer survival improved by 28% , Colorectal cancer by 17%, Breast cancer by 16%, Lung cancer by 15%). A pan-European survey of cancer related pain concluded :

- 56% suffered moderate-to-severe pain at least monthly
- 77% were receiving prescription-only analgesics
- 41% taking strong opioids either alone or with other drugs for cancer-related pain
- 50% believed that their quality of life was not considered a priority in their overall care by their health care professional

Cancer pain

Cancer patients with pain

All cancer stages 50.7%

Moderate to severe pain 33.1%

During anticancer Rx 55.0%

Moderate to severe pain 32.4%

After curative anticancer Rx 39.3%

Moderate to severe pain 27.6%

"Advanced" disease 66.4%

Moderate to severe pain 51.9%

van den Beuken-van Everdingen et al, 2016

Need for an integrated Pathway

These statistics are reflected in the progressive increase in incidence in both the complexity and chronicity of cancer related pain. This is demonstrated in an increase in referral rates to both palliative medicine services and interventional pain services. As cancer prognosis increases, this has increased the burden of patient care in both specialities. Consequently, we are seeing a growing tolerance to opioids, an increasing need for polypharmacy and an increasing incidence of adverse side effects of systemic opioids. Interventions such as nerve blocks and intramuscular injections are being used to limit the use of systemic opioids, and to improve patient's quality of life

Aims

- To improve pain management for cancer patients in a tertiary centre
- Improve access to interventional pain for patients with advanced cancer or chronic cancer-related pain
- Create an opportunity for multidisciplinary education on the role of each service and the interventions available to manage cancer related pain
- To reduce the need for systemic opioid use and polypharmacy in the management of cancer pain
- Improve and maintain patient's functional status and quality of life.

Authors: (1) Registrar in Palliative medicine, St James Hospital. (2) Registrar in Palliative medicine. (3) ANP in Pain Medicine. (4) Consultant Anesthesiologist in Pain Medicine. (5) Consultant in Palliative Medicine. (6) Consultant Anesthesiologist in Pain Medicine. (7) Consultant in Palliative Medicine. (8) Fellow in Anesthesiology and Pain Medicine. (9) Consultant in Palliative Medicine.

Methods

We developed an joint interventional pain team and palliative care team monthly meeting to create individualised management plans for patients with complex cancer pain. We applied an action research methodology of quality improvement. Approval was obtained from St James Hospital Research & Innovation office.

Results

First monthly meeting occurred in May 2024. To date, 41 patients have been discussed at these meetings. Of these patients 12 have had interventional procedures performed. These patients were referred from the inpatient palliative care service, outpatient department and the hospice setting. The format of the meeting is being continuously refined and revised to improved knowledge sharing. A steady increase in the number of patients being presented monthly is observed. A formal teaching session has been added to the meeting to maintain current best practice. The reaccreditation OECI audit of St James Hospital 2024 highlighted cancer pain management as a strength of cancer care provided by the hospital.

Types of Cancers meeting the Criteria for MDT Discussion to date

Future of integrated care pathway

- The Trinity St James Cancer Institute supports further integration of services
- Currently an OPD slot in pain clinic open for short term review of palliative care patients.
- ANP Pain clinic set up to support capsaicin therapy for peripheral neuropathy.
- Working towards the establishment of a specific cancer pain OPD clinic
- Data collection is ongoing to monitor impact on systemic opioid use, functional status and quality of life.

Conclusion

Multidisciplinary approach to complex cancer pain management improves access to interventions and outcomes for patients, increases quality of life, reduces the need for polypharmacy and reduces the incidence of hospital admission in pain crisis.

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Title: The Development of an Integrated Palliative Medicine and Pain Team Pathway

Authors: Keogh, Hayes, Daly, Brady, O'Leary, O'Gara, Fitzgerald, Shaikh, Conneely

Audits

Title: Mindful Prescribing: An audit of de-prescribing practice in the in-patient Hospice setting

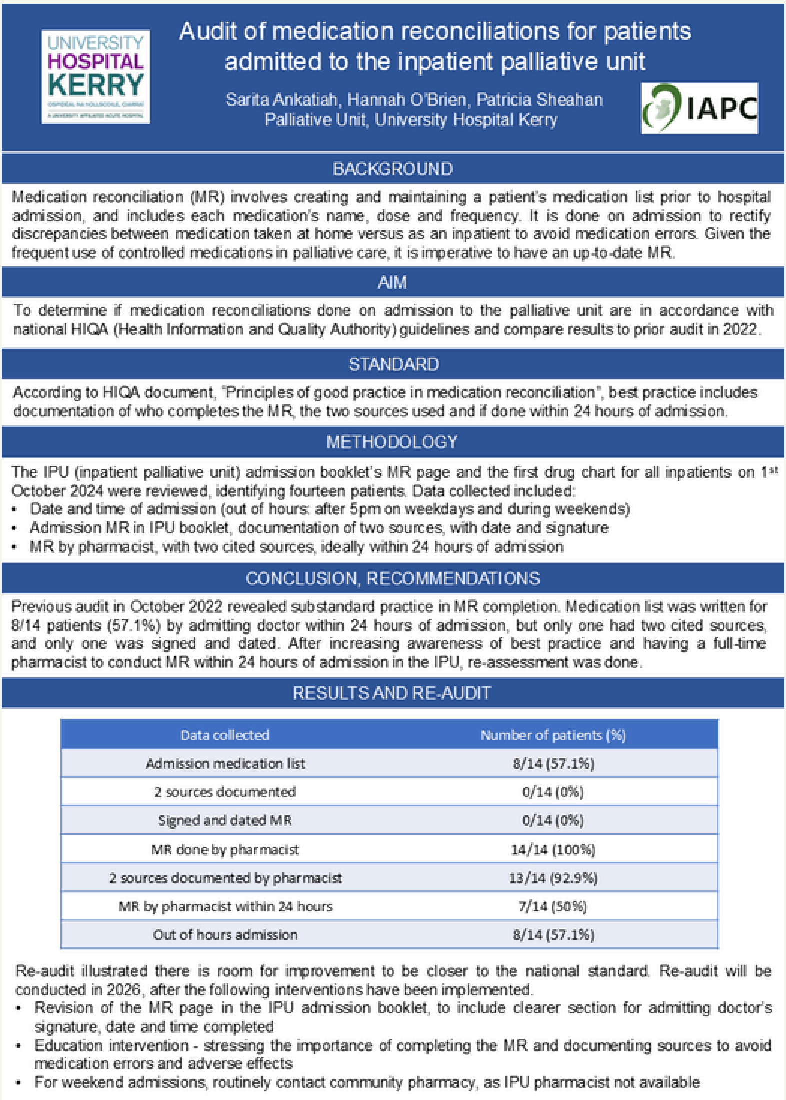
Authors: Brassil, McQuillan, Webb

Audits

Title: Syringe-driver drug stability in an Inpatient Palliative Care Unit – A Multidisciplinary Team Audit

Authors: Zia, Walsh, Cullinane, Joseph, Ryan

Audits



Audit of medication reconciliations for patients admitted to the inpatient palliative unit

Sarita Ankatiah, Hannah O'Brien, Patricia Sheahan
Palliative Unit, University Hospital Kerry

BACKGROUND

Medication reconciliation (MR) involves creating and maintaining a patient's medication list prior to hospital admission, and includes each medication's name, dose and frequency. It is done on admission to rectify discrepancies between medication taken at home versus as an inpatient to avoid medication errors. Given the frequent use of controlled medications in palliative care, it is imperative to have an up-to-date MR.

AIM

To determine if medication reconciliations done on admission to the palliative unit are in accordance with national HIQA (Health Information and Quality Authority) guidelines and compare results to prior audit in 2022.

STANDARD

According to HIQA document, "Principles of good practice in medication reconciliation", best practice includes documentation of who completes the MR, the two sources used and if done within 24 hours of admission.

METHODOLOGY

The IPU (inpatient palliative unit) admission booklet's MR page and the first drug chart for all inpatients on 1st October 2024 were reviewed, identifying fourteen patients. Data collected included:

- Date and time of admission (out of hours: after 5pm on weekdays and during weekends)
- Admission MR in IPU booklet, documentation of two sources, with date and signature
- MR by pharmacist, with two cited sources, ideally within 24 hours of admission

CONCLUSION, RECOMMENDATIONS

Previous audit in October 2022 revealed substandard practice in MR completion. Medication list was written for 8/14 patients (57.1%) by admitting doctor within 24 hours of admission, but only one had two cited sources, and only one was signed and dated. After increasing awareness of best practice and having a full-time pharmacist to conduct MR within 24 hours of admission in the IPU, re-assessment was done.

RESULTS AND RE-AUDIT

Data collected	Number of patients (%)
Admission medication list	8/14 (57.1%)
2 sources documented	0/14 (0%)
Signed and dated MR	0/14 (0%)
MR done by pharmacist	14/14 (100%)
2 sources documented by pharmacist	13/14 (92.9%)
MR by pharmacist within 24 hours	7/14 (50%)
Out of hours admission	8/14 (57.1%)

Re-audit illustrated there is room for improvement to be closer to the national standard. Re-audit will be conducted in 2026, after the following interventions have been implemented.

- Revision of the MR page in the IPU admission booklet, to include clearer section for admitting doctor's signature, date and time completed
- Education intervention - stressing the importance of completing the MR and documenting sources to avoid medication errors and adverse effects
- For weekend admissions, routinely contact community pharmacy, as IPU pharmacist not available

Title: Audit of medication reconciliations for patients admitted to the inpatient palliative unit (IPU)

Authors: Ankatiah, Drury, O'Brien, Sheahan

Audits

Clinical Audit & Effectiveness

Management of Diabetes Mellitus at the End-of-Life – A reaudit of adherence to local hospital guidelines

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1. Palliative Care Department, Mater Misericordiae University Hospital, Dublin 7
2. St Francis Hospice, Blanchardstown, Dublin 15
3. UCD School of Medicine, University College Dublin, Belfield, Dublin 4

Background and Rationale for Audit

At the end of life, the goals of diabetes management should change ensuring a patient-centered, comfort-focused approach with clear communication.[1] To improve local management of diabetes mellitus at end of life in Mater Misericordiae University Hospital (MMUH), a policy was developed considering local practices, staff concerns, local experts and international evidence. This policy was published in 2022 once approved by the local Drugs and Therapeutics Committee. A Plan-Do-Study-Act (PDSA) method was implemented. Adherence to the policy was audited in 2023. It demonstrated room for improvement in diabetes management at end of life. An education campaign was completed, including presentation at MMUH Clinical Audit Week and targeted education to clinical nurse specialists, clinical nurse managers and endocrinology NCHDs. The local specialist palliative care team also promoted the policy where appropriate to patient's care.

Aim

Reaudit to evaluate the success of education programmes on local management of diabetes mellitus at the end of life.

Methodology

- A pseudo-anonymised, retrospective chart review was undertaken.
- Patients who died under the palliative care team with a diagnosis of diabetes were identified using electronic medical records.
- 162 patients were screened.
- Data was collected using Microsoft Excel.
- Descriptive statistics were generated.

Standards:

Published policy "Management of Diabetes Mellitus at End-of-Life Palliation (Comfort Care)".[2] The original standards were re-audited:

1. Clearly documented decision-making surrounding diabetes management at the end of life.
2. Evidence of appropriate communication with patient/family regarding diabetes management at the end of life.
3. Blood glucose level testing appropriately reduced/stopped as a person approaches the end of life.
4. Oral hypoglycaemic agents appropriately discontinued as a person approaches end of life.
5. Insulin is reduced when oral intake diminishes.

Results of the Re-Audit

24 patients; Type 2 Diabetes Mellitus in 23 and Type 1 in one patient.

Figure 1 provides comparison to the original audit.

Standard 1: Clearly documented decision-making surrounding diabetes management at the end of life. This was met in 7/24 (29%).

Standard 2: Evidence of appropriate communication with patient/family regarding diabetes management at the end of life. This was met in 4/24 (17%).

Standard 3: Blood glucose level testing appropriately reduced/stopped as a person approaches the end of life. This was met in 17/23 (74%). 1 chart was excluded due to incomplete data.

Standard 4: Oral hypoglycaemic agents appropriately discontinued as a person approaches end of life. This was met in 18/20 (90%). Four charts were excluded as these patients were not on oral hypoglycaemic agents.

Standard 5: Insulin is reduced when oral intake diminishes: This was met in 4/6 (67%) of patients who were on insulin. 18/24 (75%) of patients were not on insulin.

Figure 1: Reaudit Results

Conclusions

While continued room for improvement exists, this reaudit suggests that efforts aimed at implementation of the policy and sustaining the change are improving adherence to local standards on the management of diabetes at the end of life, and in turn patient care. All audited standards showed improvement. Stakeholder buy-in is crucial for successful change management, and targeted education sessions and policy awareness efforts have proven beneficial during this PDSA cycle. However, communication and documentation around diabetes management at the end of life remain poor, reflecting themes in the available literature. This will be a key focus for the next PDSA cycle.

Action Plan

1. Continued promotion of the policy at ward level via the palliative care team for relevant patients to improve adherence.
2. Ongoing stakeholder engagement to determine effective strategies to promote policy use and sustainability.
3. Further education on the management of diabetes at the end of life and use of the guideline will be provided for both medical and nursing staff.
4. Reaudit to be completed after the next PDSA cycle.

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1. Diabetes UK. (2021). End of life guidance for diabetes care. In (4th Edition ed.). United Kingdom: Trend Diabetes.
2. Taheny, K., Kieran, M., Ryan, K., & Hatunic, M. (2022) The Management of Diabetes Mellitus at the End-Of-Life. The Mater Misericordiae University Hospital

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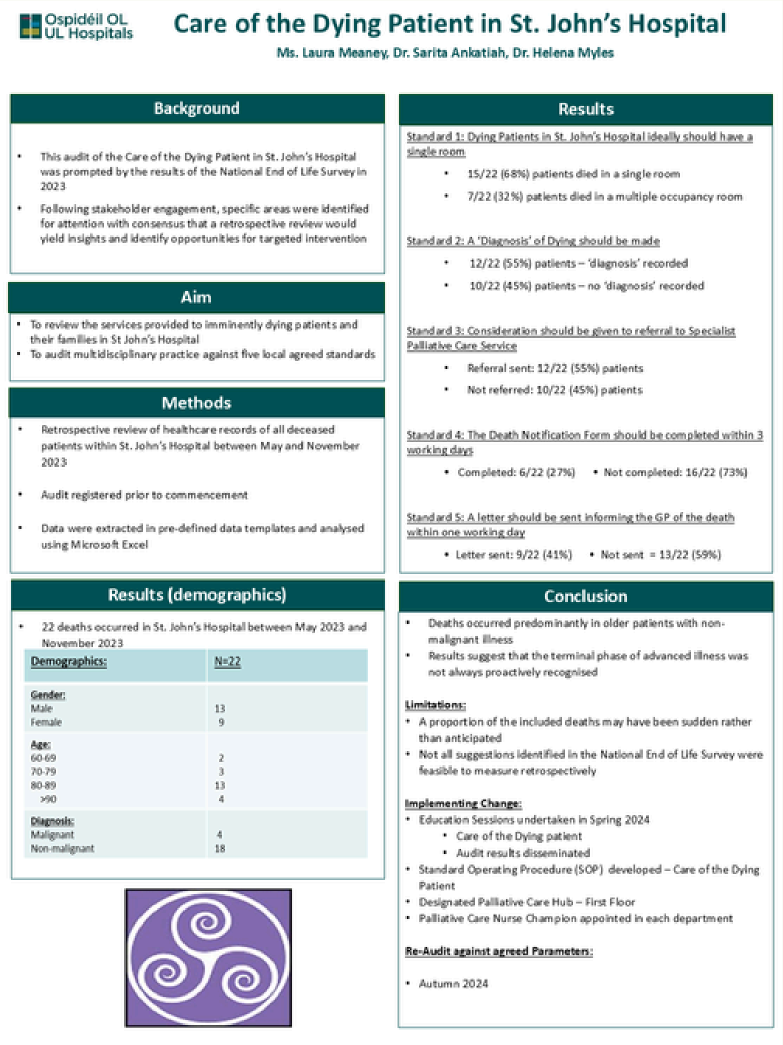
Title: Management of Diabetes Mellitus at the End-of-Life – A reaudit of adherence to local hospital guidelines

Authors: Taheny, Harrington, O'Connor, Ryan

Audits



Ospidéil OL
UL Hospitals

Care of the Dying Patient in St. John's Hospital

Ms. Laura Meaney, Dr. Sarita Ankatiah, Dr. Helena Myles

Background

- This audit of the Care of the Dying Patient in St. John's Hospital was prompted by the results of the National End of Life Survey in 2023
- Following stakeholder engagement, specific areas were identified for attention with consensus that a retrospective review would yield insights and identify opportunities for targeted intervention

Aim

- To review the services provided to imminently dying patients and their families in St John's Hospital
- To audit multidisciplinary practice against five local agreed standards

Methods

- Retrospective review of healthcare records of all deceased patients within St. John's Hospital between May and November 2023
- Audit registered prior to commencement
- Data were extracted in pre-defined data templates and analysed using Microsoft Excel

Results (demographics)

- 22 deaths occurred in St. John's Hospital between May 2023 and November 2023

Demographics:	N=22
Gender:	
Male	13
Female	9
Age:	
60-69	2
70-79	3
80-89	13
>90	4
Diagnosis:	
Malignant	4
Non-malignant	18

Results

Standard 1: Dying Patients in St. John's Hospital ideally should have a single room

- 15/22 (68%) patients died in a single room
- 7/22 (32%) patients died in a multiple occupancy room

Standard 2: A 'Diagnosis' of Dying should be made

- 12/22 (55%) patients – 'diagnosis' recorded
- 10/22 (45%) patients – no 'diagnosis' recorded

Standard 3: Consideration should be given to referral to Specialist Palliative Care Service

- Referral sent: 12/22 (55%) patients
- Not referred: 10/22 (45%) patients

Standard 4: The Death Notification Form should be completed within 3 working days

- Completed: 6/22 (27%)
- Not completed: 16/22 (73%)

Standard 5: A letter should be sent informing the GP of the death within one working day

- Letter sent: 9/22 (41%)
- Not sent = 13/22 (59%)

Conclusion

- Deaths occurred predominantly in older patients with non-malignant illness
- Results suggest that the terminal phase of advanced illness was not always proactively recognised

Limitations:

- A proportion of the included deaths may have been sudden rather than anticipated
- Not all suggestions identified in the National End of Life Survey were feasible to measure retrospectively

Implementing Change:

- Education Sessions undertaken in Spring 2024
  - Care of the Dying patient
  - Audit results disseminated
- Standard Operating Procedure (SOP) developed – Care of the Dying Patient
- Designated Palliative Care Hub – First Floor
- Palliative Care Nurse Champion appointed in each department

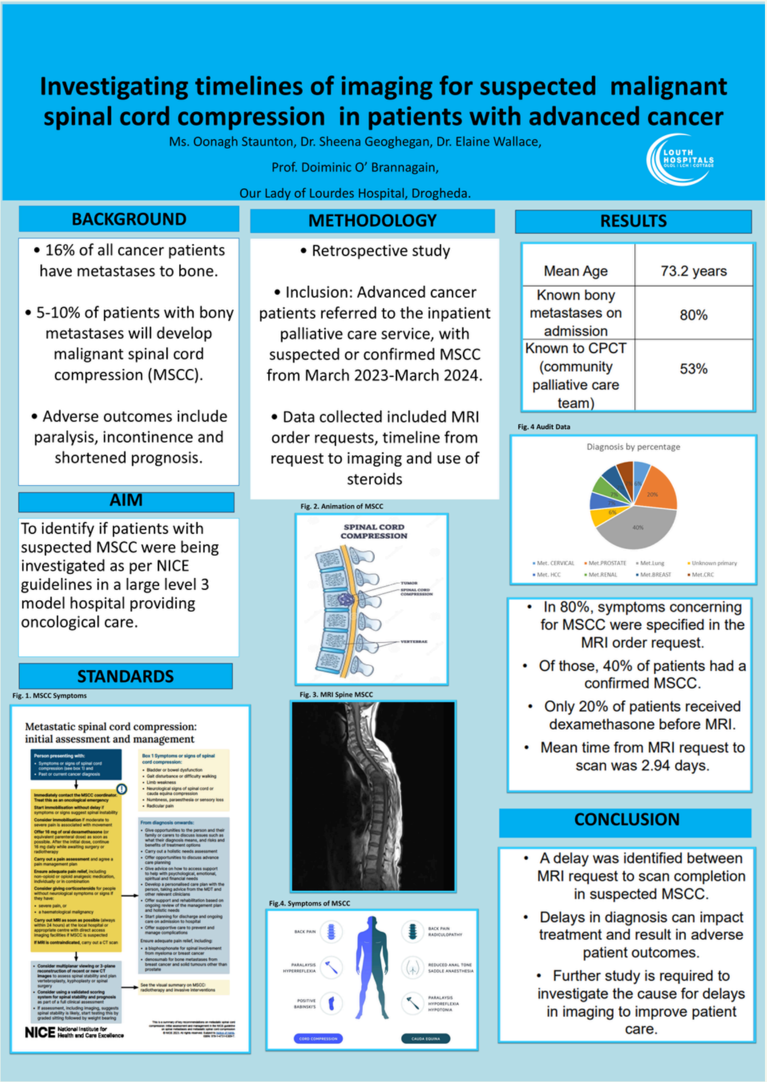
Re-Audit against agreed Parameters:

- Autumn 2024

Title: Care of the Dying Patient in St. John's Hospital, Limerick: An Audit

Authors: Meaney, Myles

Audits



Investigating timelines of imaging for suspected malignant spinal cord compression in patients with advanced cancer

Ms. Oonagh Staunton, Dr. Sheena Geoghegan, Dr. Elaine Wallace,

Prof. Doiminic O' Brannagain,

Our Lady of Lourdes Hospital, Drogheda.

BACKGROUND

- 16% of all cancer patients have metastases to bone.
- 5-10% of patients with bony metastases will develop malignant spinal cord compression (MSCC).
- Adverse outcomes include paralysis, incontinence and shortened prognosis.

AIM

To identify if patients with suspected MSCC were being investigated as per NICE guidelines in a large level 3 model hospital providing oncological care.

STANDARDS

Fig. 1. MSCC Symptoms

Metastatic spinal cord compression: initial assessment and management

Person presenting with:
- Symptoms or signs of spinal cord compression (see box 1) and
- Past or current cancer diagnosis

Immediately contact the MSCC coordinator. Treat this as an oncological emergency

Start immobilisation without delay if symptoms or signs suggest spinal instability

Consider immobilisation if moderate to severe pain is associated with movement

Offer 16 mg of oral dexamethasone (or equivalent parenteral dose) as soon as possible. After the initial dose, continue 16 mg daily while awaiting surgery or radiotherapy

Carry out a pain assessment and agree a pain management plan

Ensure adequate pain relief, including non-opioid or opioid analgesic medication, individually or in combination

Consider giving corticosteroids for people without neurological symptoms or signs if they have:
- severe pain, or
- a haematological malignancy

Carry out MRI as soon as possible (always within 24 hours) at the local hospital or appropriate centre with direct access imaging facilities if MSCC is suspected

If MRI is contraindicated, carry out a CT scan

- **Consider multiplanar viewing or 3-plane reconstruction of recent or new CT images** to assess spinal stability and plan vertebroplasty, kyphoplasty or spinal surgery
- **Consider using a validated scoring system for spinal stability and prognosis** as part of a full clinical assessment
- If assessment, including imaging, suggests spinal stability is likely, start testing this by graded sitting followed by weight bearing

Box 1 Symptoms or signs of spinal cord compression:
- Bladder or bowel dysfunction
- Gait disturbance or difficulty walking
- Limb weakness
- Neurological signs of spinal cord or cauda equina compression
- Numbness, paraesthesia or sensory loss
- Radicular pain

From diagnosis onwards:
- Give opportunities to the person and their family or carers to discuss issues such as what their diagnosis means, and risks and benefits of treatment options
- Carry out a holistic needs assessment
- Offer opportunities to discuss advance care planning
- Give advice on how to access support to help with psychological, emotional, spiritual and financial needs
- Develop a personalised care plan with the person, taking advice from the MDT and other relevant clinicians
- Offer support and rehabilitation based on ongoing review of the management plan and holistic needs
- Start planning for discharge and ongoing care on admission to hospital
- Offer supportive care to prevent and manage complications

Ensure adequate pain relief, including:
- a bisphosphonate for spinal involvement from myeloma or breast cancer
- denosumab for bone metastases from breast cancer and solid tumours other than prostate

See the visual summary on MSCC: radiotherapy and invasive interventions

NICE National Institute for Health and Care Excellence

METHODOLOGY

- Retrospective study
- Inclusion: Advanced cancer patients referred to the inpatient palliative care service, with suspected or confirmed MSCC from March 2023-March 2024.
- Data collected included MRI order requests, timeline from request to imaging and use of steroids

Fig. 2. Animation of MSCC

Fig. 3. MRI Spine MSCC

Fig.4. Symptoms of MSCC

RESULTS

Mean Age	73.2 years
Known bony metastases on admission	80%
Known to CPCT (community palliative care team)	53%

Fig. 4 Audit Data

- In 80%, symptoms concerning for MSCC were specified in the MRI order request.
- Of those, 40% of patients had a confirmed MSCC.
- Only 20% of patients received dexamethasone before MRI.
- Mean time from MRI request to scan was 2.94 days.

CONCLUSION

- A delay was identified between MRI request to scan completion in suspected MSCC.
- Delays in diagnosis can impact treatment and result in adverse patient outcomes.
- Further study is required to investigate the cause for delays in imaging to improve patient care.

Title: Investigating timelines of imaging for suspected malignant spinal cord compression in patients with advanced cancer.

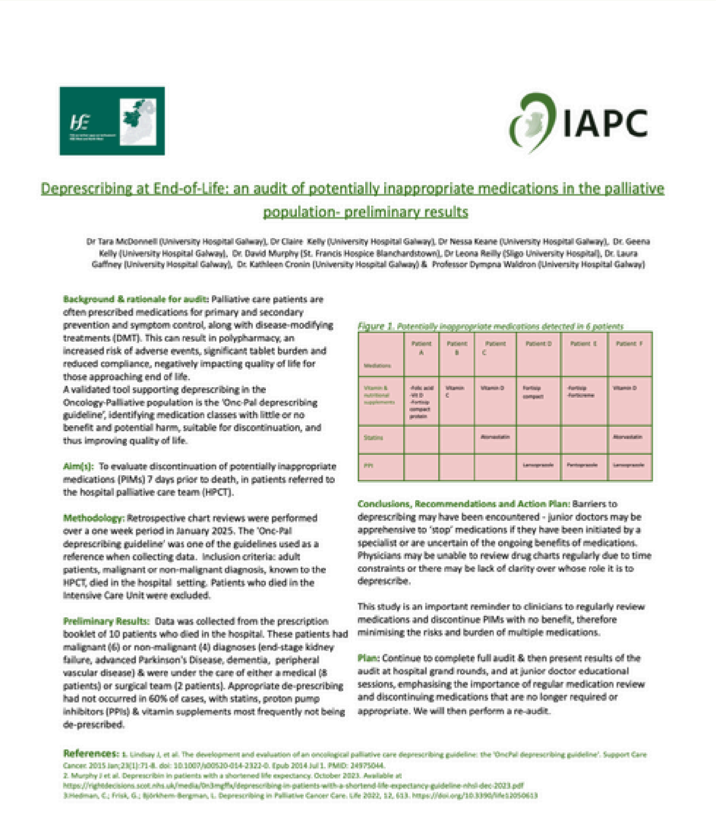
Authors: Geoghegan, Staunton, Wallace, O' Brannagain

Audits

Title: Essential Prescribing at End-of-Life: A Clinical Audit

Authors: McDonnell, Keane, Kelly, Reilly, Gaffney, Cronin, Waldron

Audits



Deprescribing at End-of-Life: an audit of potentially inappropriate medications in the palliative population- preliminary results

Dr Tara McDonnell (University Hospital Galway), Dr Claire Kelly (University Hospital Galway), Dr Nessa Keane (University Hospital Galway), Dr. Geena Kelly (University Hospital Galway), Dr. David Murphy (St. Francis Hospice Blanchardstown), Dr Leona Reilly (Sligo University Hospital), Dr. Laura Gaffney (University Hospital Galway), Dr. Kathleen Cronin (University Hospital Galway) & Professor Dympna Waldron (University Hospital Galway)

Background & rationale for audit: Palliative care patients are often prescribed medications for primary and secondary prevention and symptom control, along with disease-modifying treatments (DMT). This can result in polypharmacy, an increased risk of adverse events, significant tablet burden and reduced compliance, negatively impacting quality of life for those approaching end of life.

A validated tool supporting deprescribing in the Oncology-Palliative population is the 'Onc-Pal deprescribing guideline', identifying medication classes with little or no benefit and potential harm, suitable for discontinuation, and thus improving quality of life.

Aim(s): To evaluate discontinuation of potentially inappropriate medications (PIMs) 7 days prior to death, in patients referred to the hospital palliative care team (HPCT).

Methodology: Retrospective chart reviews were performed over a one week period in January 2025. The 'Onc-Pal depresribing guideline' was one of the guidelines used as a reference when collecting data. Inclusion criteria: adult patients, malignant or non-malignant diagnosis, known to the HPCT, died in the hospital setting. Patients who died in the Intensive Care Unit were excluded.

Preliminary Results: Data was collected from the prescription booklet of 10 patients who died in the hospital. These patients had malignant (6) or non-malignant (4) diagnoses (end-stage kidney failure, advanced Parkinson's Disease, dementia, peripheral vascular disease) & were under the care of either a medical (8 patients) or surgical team (2 patients). Appropriate de-prescribing had not occurred in 60% of cases, with statins, proton pump inhibitors (PPIs) & vitamin supplements most frequently not being de-prescribed.

Figure 1. Potentially inappropriate medications detected in 6 patients

Medications	Patient A	Patient B	Patient C	Patient D	Patient E	Patient F
Vitamin & nutritional supplements	-Folic acid -Vit D -Fortisip compact protein	Vitamin C	Vitamin D	Fortisip compact	-Fortisip -Forticreme	Vitamin D
Statins			Atorvastatin			Atorvastatin
PPI				Lansoprazole	Pantoprazole	Lansoprazole

Conclusions, Recommendations and Action Plan: Barriers to deprescribing may have been encountered - junior doctors may be apprehensive to 'stop' medications if they have been initiated by a specialist or are uncertain of the ongoing benefits of medications. Physicians may be unable to review drug charts regularly due to time constraints or there may be lack of clarity over whose role it is to deprescribe.

This study is an important reminder to clinicians to regularly review medications and discontinue PIMs with no benefit, therefore minimising the risks and burden of multiple medications.

Plan: Continue to complete full audit & then present results of the audit at hospital grand rounds, and at junior doctor educational sessions, emphasising the importance of regular medication review and discontinuing medications that are no longer required or appropriate. We will then perform a re-audit.

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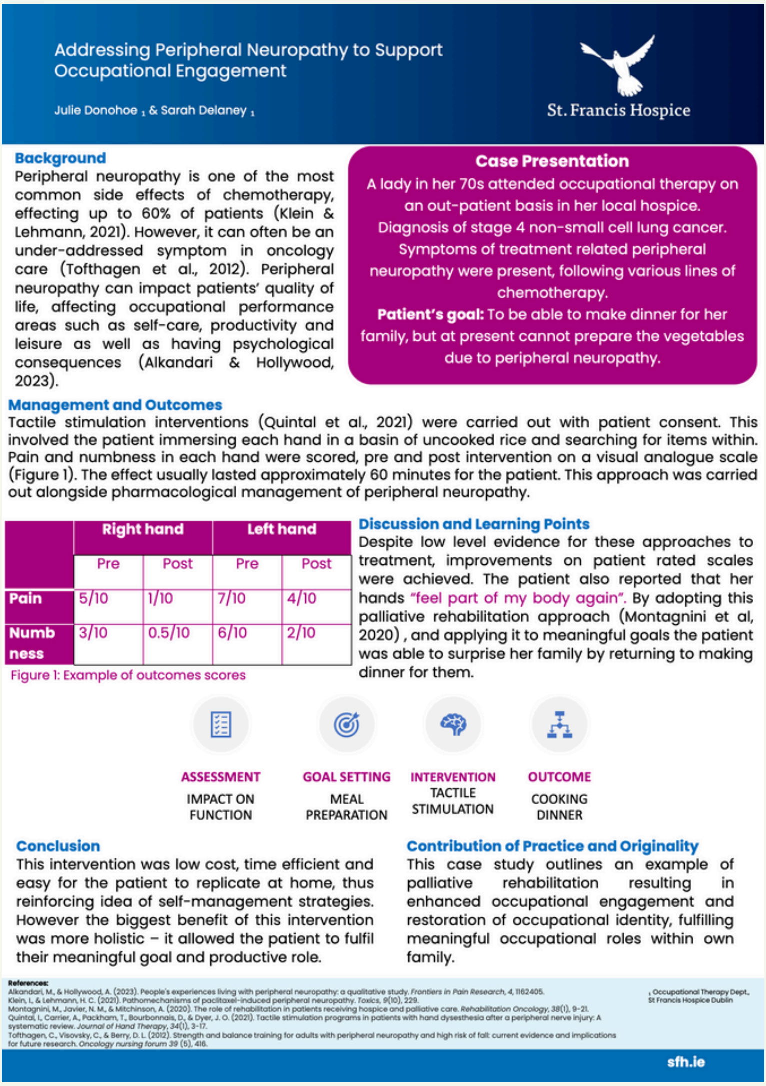
3.Hedman, C.; Frisk, G.; Björkhem-Bergman, L. Depresoribing in Palliative Cancer Care. Life 2022, 12, 613. https://doi.org/10.3390/life12050613

Title: Deprescribing at End-of-Life: an audit of potentially Inappropriate medications in the palliative population

Authors: McDonnell, Keane, Kelly, Murphy, Reilly, Gaffney, Cronin, Waldron

Case Reports



Addressing Peripheral Neuropathy to Support Occupational Engagement

Julie Donohoe [1] & Sarah Delaney [1]

St. Francis Hospice

Background

Peripheral neuropathy is one of the most common side effects of chemotherapy, effecting up to 60% of patients (Klein & Lehmann, 2021). However, it can often be an under-addressed symptom in oncology care (Tofthagen et al., 2012). Peripheral neuropathy can impact patients' quality of life, affecting occupational performance areas such as self-care, productivity and leisure as well as having psychological consequences (Alkandari & Hollywood, 2023).

Case Presentation

A lady in her 70s attended occupational therapy on an out-patient basis in her local hospice. Diagnosis of stage 4 non-small cell lung cancer. Symptoms of treatment related peripheral neuropathy were present, following various lines of chemotherapy.

Patient's goal: To be able to make dinner for her family, but at present cannot prepare the vegetables due to peripheral neuropathy.

Management and Outcomes

Tactile stimulation interventions (Quintal et al., 2021) were carried out with patient consent. This involved the patient immersing each hand in a basin of uncooked rice and searching for items within. Pain and numbness in each hand were scored, pre and post intervention on a visual analogue scale (Figure 1). The effect usually lasted approximately 60 minutes for the patient. This approach was carried out alongside pharmacological management of peripheral neuropathy.

	Right hand		Left hand	
	Pre	Post	Pre	Post
Pain	5/10	1/10	7/10	4/10
Numbness	3/10	0.5/10	6/10	2/10

Figure 1: Example of outcomes scores

Discussion and Learning Points

Despite low level evidence for these approaches to treatment, improvements on patient rated scales were achieved. The patient also reported that her hands "feel part of my body again". By adopting this palliative rehabilitation approach (Montagnini et al, 2020) , and applying it to meaningful goals the patient was able to surprise her family by returning to making dinner for them.

ASSESSMENT
IMPACT ON FUNCTION

GOAL SETTING
MEAL PREPARATION

INTERVENTION
TACTILE STIMULATION

OUTCOME
COOKING DINNER

Conclusion

This intervention was low cost, time efficient and easy for the patient to replicate at home, thus reinforcing idea of self-management strategies. However the biggest benefit of this intervention was more holistic – it allowed the patient to fulfil their meaningful goal and productive role.

Contribution of Practice and Originality

This case study outlines an example of palliative rehabilitation resulting in enhanced occupational engagement and restoration of occupational identity, fulfilling meaningful occupational roles within own family.

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Tofthagen, C., Visovsky, C., & Berry, D. L. (2012). Strength and balance training for adults with peripheral neuropathy and high risk of fall: current evidence and implications for future research. *Oncology nursing forum 39* (5), 416.

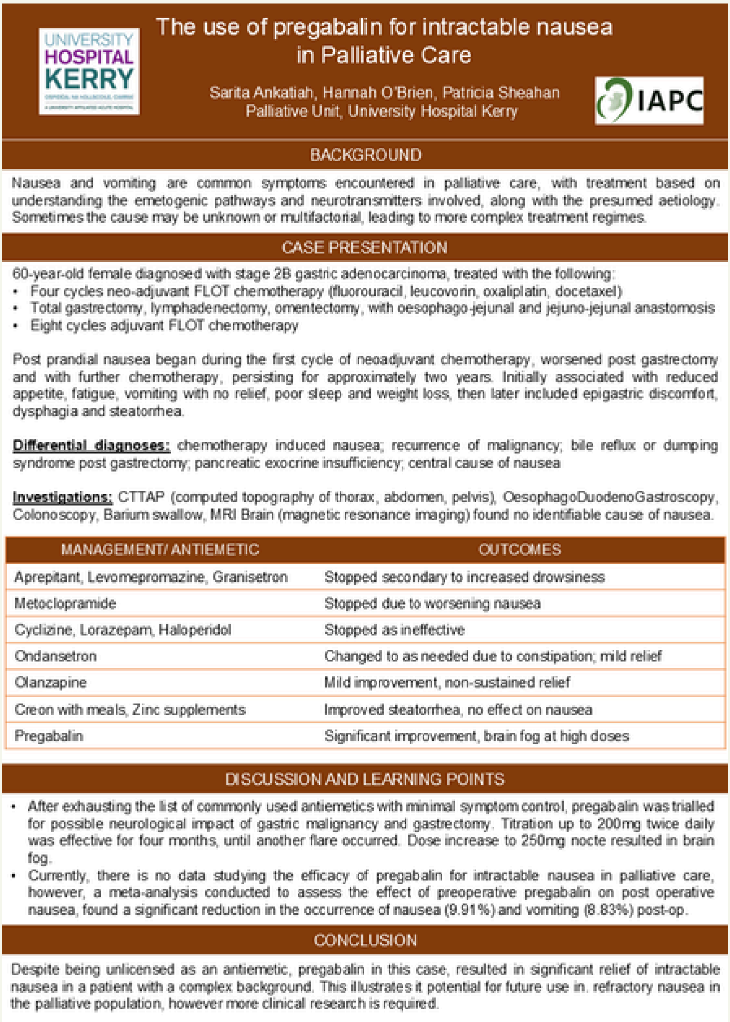
[1] Occupational Therapy Dept., St Francis Hospice Dublin

sfh.ie

Title: Addressing Peripheral Neuropathy to support Occupational Engagement

Authors: Donohue, Delaney

Case Reports



The use of pregabalin for intractable nausea in Palliative Care

Sarita Ankatiah, Hannah O'Brien, Patricia Sheahan
Palliative Unit, University Hospital Kerry

BACKGROUND

Nausea and vomiting are common symptoms encountered in palliative care, with treatment based on understanding the emetogenic pathways and neurotransmitters involved, along with the presumed aetiology. Sometimes the cause may be unknown or multifactorial, leading to more complex treatment regimes.

CASE PRESENTATION

60-year-old female diagnosed with stage 2B gastric adenocarcinoma, treated with the following:
- Four cycles neo-adjuvant FLOT chemotherapy (fluorouracil, leucovorin, oxaliplatin, docetaxel)
- Total gastrectomy, lymphadenectomy, omentectomy, with oesophago-jejunal and jejuno-jejunal anastomosis
- Eight cycles adjuvant FLOT chemotherapy

Post prandial nausea began during the first cycle of neoadjuvant chemotherapy, worsened post gastrectomy and with further chemotherapy, persisting for approximately two years. Initially associated with reduced appetite, fatigue, vomiting with no relief, poor sleep and weight loss, then later included epigastric discomfort, dysphagia and steatorrhea.

Differential diagnoses: chemotherapy induced nausea; recurrence of malignancy; bile reflux or dumping syndrome post gastrectomy; pancreatic exocrine insufficiency; central cause of nausea

Investigations: CTTAP (computed topography of thorax, abdomen, pelvis), OesophagoDuodenoGastroscopy, Colonoscopy, Barium swallow, MRI Brain (magnetic resonance imaging) found no identifiable cause of nausea.

MANAGEMENT/ ANTIEMETIC	OUTCOMES
Aprepitant, Levomepromazine, Granisetron	Stopped secondary to increased drowsiness
Metoclopramide	Stopped due to worsening nausea
Cyclizine, Lorazepam, Haloperidol	Stopped as ineffective
Ondansetron	Changed to as needed due to constipation; mild relief
Olanzapine	Mild improvement, non-sustained relief
Creon with meals, Zinc supplements	Improved steatorrhea, no effect on nausea
Pregabalin	Significant improvement, brain fog at high doses

DISCUSSION AND LEARNING POINTS

- After exhausting the list of commonly used antiemetics with minimal symptom control, pregabalin was trialled for possible neurological impact of gastric malignancy and gastrectomy. Titration up to 200mg twice daily was effective for four months, until another flare occurred. Dose increase to 250mg nocte resulted in brain fog.
- Currently, there is no data studying the efficacy of pregabalin for intractable nausea in palliative care, however, a meta-analysis conducted to assess the effect of preoperative pregabalin on post operative nausea, found a significant reduction in the occurrence of nausea (9.91%) and vomiting (8.83%) post-op.

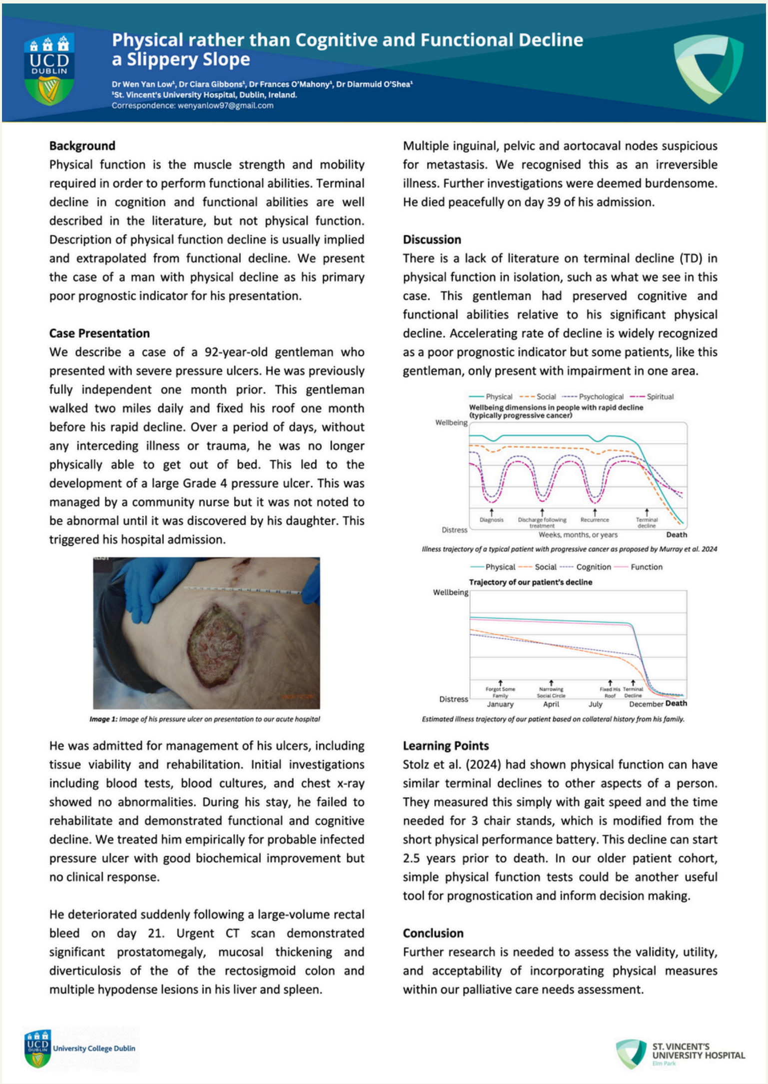
CONCLUSION

Despite being unlicensed as an antiemetic, pregabalin in this case, resulted in significant relief of intractable nausea in a patient with a complex background. This illustrates it potential for future use in. refractory nausea in the palliative population, however more clinical research is required.

Title: The use of pregabalin for intractable nausea in palliative care

Authors: Ankatiah, O'Brien, Sheahan

Case Reports



Physical rather than Cognitive and Functional Decline a Slippery Slope

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Background

Physical function is the muscle strength and mobility required in order to perform functional abilities. Terminal decline in cognition and functional abilities are well described in the literature, but not physical function. Description of physical function decline is usually implied and extrapolated from functional decline. We present the case of a man with physical decline as his primary poor prognostic indicator for his presentation.

Case Presentation

We describe a case of a 92-year-old gentleman who presented with severe pressure ulcers. He was previously fully independent one month prior. This gentleman walked two miles daily and fixed his roof one month before his rapid decline. Over a period of days, without any interceding illness or trauma, he was no longer physically able to get out of bed. This led to the development of a large Grade 4 pressure ulcer. This was managed by a community nurse but it was not noted to be abnormal until it was discovered by his daughter. This triggered his hospital admission.

Image 1: Image of his pressure ulcer on presentation to our acute hospital

He was admitted for management of his ulcers, including tissue viability and rehabilitation. Initial investigations including blood tests, blood cultures, and chest x-ray showed no abnormalities. During his stay, he failed to rehabilitate and demonstrated functional and cognitive decline. We treated him empirically for probable infected pressure ulcer with good biochemical improvement but no clinical response.

He deteriorated suddenly following a large-volume rectal bleed on day 21. Urgent CT scan demonstrated significant prostatomegaly, mucosal thickening and diverticulosis of the of the rectosigmoid colon and multiple hypodense lesions in his liver and spleen. Multiple inguinal, pelvic and aortocaval nodes suspicious for metastasis. We recognised this as an irreversible illness. Further investigations were deemed burdensome. He died peacefully on day 39 of his admission.

Discussion

There is a lack of literature on terminal decline (TD) in physical function in isolation, such as what we see in this case. This gentleman had preserved cognitive and functional abilities relative to his significant physical decline. Accelerating rate of decline is widely recognized as a poor prognostic indicator but some patients, like this gentleman, only present with impairment in one area.

Illness trajectory of a typical patient with progressive cancer as proposed by Murray et al. 2024

Estimated illness trajectory of our patient based on collateral history from his family.

Learning Points

Stolz et al. (2024) had shown physical function can have similar terminal declines to other aspects of a person. They measured this simply with gait speed and the time needed for 3 chair stands, which is modified from the short physical performance battery. This decline can start 2.5 years prior to death. In our older patient cohort, simple physical function tests could be another useful tool for prognostication and inform decision making.

Conclusion

Further research is needed to assess the validity, utility, and acceptability of incorporating physical measures within our palliative care needs assessment.

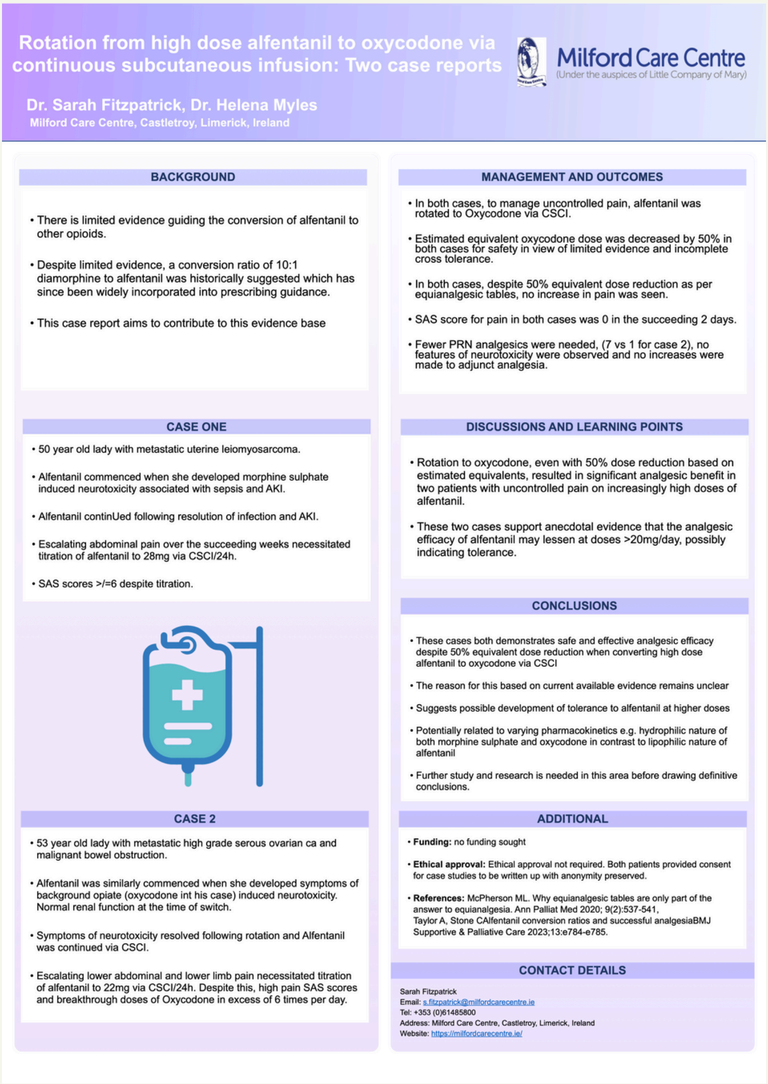
University College Dublin

ST. VINCENT'S UNIVERSITY HOSPITAL
Elm Park

Title: Physical rather than Cognitive and Functional Decline – A Slippery Slope

Authors: Low, Gibbons, O'Mahony, O'Shea

Case Reports



Rotation from high dose alfentanil to oxycodone via continuous subcutaneous infusion: Two case reports

Milford Care Centre
(Under the auspices of Little Company of Mary)

Dr. Sarah Fitzpatrick, Dr. Helena Myles
Milford Care Centre, Castletroy, Limerick, Ireland

BACKGROUND

- There is limited evidence guiding the conversion of alfentanil to other opioids.
- Despite limited evidence, a conversion ratio of 10:1 diamorphine to alfentanil was historically suggested which has since been widely incorporated into prescribing guidance.
- This case report aims to contribute to this evidence base

CASE ONE

- 50 year old lady with metastatic uterine leiomyosarcoma.
- Alfentanil commenced when she developed morphine sulphate induced neurotoxicity associated with sepsis and AKI.
- Alfentanil continUed following resolution of infection and AKI.
- Escalating abdominal pain over the succeeding weeks necessitated titration of alfentanil to 28mg via CSCI/24h.
- SAS scores >/=6 despite titration.

CASE 2

- 53 year old lady with metastatic high grade serous ovarian ca and malignant bowel obstruction.
- Alfentanil was similarly commenced when she developed symptoms of background opiate (oxycodone int his case) induced neurotoxicity. Normal renal function at the time of switch.
- Symptoms of neurotoxicity resolved following rotation and Alfentanil was continued via CSCI.
- Escalating lower abdominal and lower limb pain necessitated titration of alfentanil to 22mg via CSCI/24h. Despite this, high pain SAS scores and breakthrough doses of Oxycodone in excess of 6 times per day.

MANAGEMENT AND OUTCOMES

- In both cases, to manage uncontrolled pain, alfentanil was rotated to Oxycodone via CSCI.
- Estimated equivalent oxycodone dose was decreased by 50% in both cases for safety in view of limited evidence and incomplete cross tolerance.
- In both cases, despite 50% equivalent dose reduction as per equianalgesic tables, no increase in pain was seen.
- SAS score for pain in both cases was 0 in the succeeding 2 days.
- Fewer PRN analgesics were needed, (7 vs 1 for case 2), no features of neurotoxicity were observed and no increases were made to adjunct analgesia.

DISCUSSIONS AND LEARNING POINTS

- Rotation to oxycodone, even with 50% dose reduction based on estimated equivalents, resulted in significant analgesic benefit in two patients with uncontrolled pain on increasingly high doses of alfentanil.
- These two cases support anecdotal evidence that the analgesic efficacy of alfentanil may lessen at doses >20mg/day, possibly indicating tolerance.

CONCLUSIONS

- These cases both demonstrates safe and effective analgesic efficacy despite 50% equivalent dose reduction when converting high dose alfentanil to oxycodone via CSCI
- The reason for this based on current available evidence remains unclear
- Suggests possible development of tolerance to alfentanil at higher doses
- Potentially related to varying pharmacokinetics e.g. hydrophilic nature of both morphine sulphate and oxycodone in contrast to lipophilic nature of alfentanil
- Further study and research is needed in this area before drawing definitive conclusions.

ADDITIONAL

- **Funding:** no funding sought
- **Ethical approval:** Ethical approval not required. Both patients provided consent for case studies to be written up with anonymity preserved.
- **References:** McPherson ML. Why equianalgesic tables are only part of the answer to equianalgesia. Ann Palliat Med 2020; 9(2):537-541,
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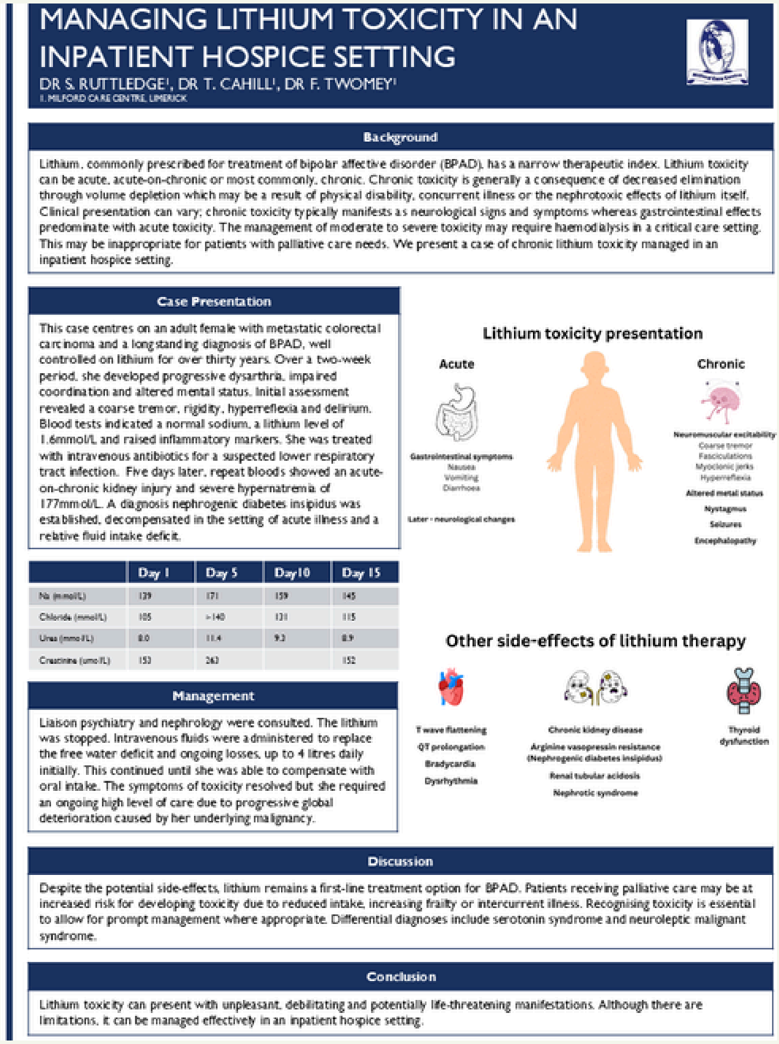
Title: Rotation from high dose alfentanil to oxycodone via continuous subcutaneous infusion: Two case reports

Authors: Fitzpatrick, Myles

Case Reports



MANAGING LITHIUM TOXICITY IN AN INPATIENT HOSPICE SETTING

DR S. RUTTLEDGE[1], DR T. CAHILL[1], DR F. TWOMEY[1]
1. MILFORD CARE CENTRE, LIMERICK

Background

Lithium, commonly prescribed for treatment of bipolar affective disorder (BPAD), has a narrow therapeutic index. Lithium toxicity can be acute, acute-on-chronic or most commonly, chronic. Chronic toxicity is generally a consequence of decreased elimination through volume depletion which may be a result of physical disability, concurrent illness or the nephrotoxic effects of lithium itself. Clinical presentation can vary; chronic toxicity typically manifests as neurological signs and symptoms whereas gastrointestinal effects predominate with acute toxicity. The management of moderate to severe toxicity may require haemodialysis in a critical care setting. This may be inappropriate for patients with palliative care needs. We present a case of chronic lithium toxicity managed in an inpatient hospice setting.

Case Presentation

This case centres on an adult female with metastatic colorectal carcinoma and a long standing diagnosis of BPAD, well controlled on lithium for over thirty years. Over a two-week period, she developed progressive dysarthria, impaired coordination and altered mental status. Initial assessment revealed a coarse tremor, rigidity, hyperreflexia and delirium. Blood tests indicated a normal sodium, a lithium level of 1.6mmol/L and raised inflammatory markers. She was treated with intravenous antibiotics for a suspected lower respiratory tract infection. Five days later, repeat bloods showed an acute-on-chronic kidney injury and severe hypernatremia of 177mmol/L. A diagnosis nephrogenic diabetes insipidus was established, decompensated in the setting of acute illness and a relative fluid intake deficit.

	Day 1	Day 5	Day 10	Day 15
Na (mmol/L)	139	171	159	145
Chloride (mmol/L)	105	>140	131	115
Urea (mmol/L)	8.0	11.4	9.3	8.9
Creatinine (umol/L)	153	263		152

Management

Liaison psychiatry and nephrology were consulted. The lithium was stopped. Intravenous fluids were administered to replace the free water deficit and ongoing losses, up to 4 litres daily initially. This continued until she was able to compensate with oral intake. The symptoms of toxicity resolved but she required an ongoing high level of care due to progressive global deterioration caused by her underlying malignancy.

Lithium toxicity presentation

Acute

Gastrointestinal symptoms
Nausea
Vomiting
Diarrhoea

Later - neurological changes

Chronic

Neuromuscular excitability
Coarse tremor
Fasciculations
Myoclonic jerks
Hyperreflexia

Altered metal status

Nystagmus

Seizures

Encephalopathy

Other side-effects of lithium therapy

T wave flattening
QT prolongation
Bradycardia
Dysrhythmia

Chronic kidney disease
Arginine vasopressin resistance (Nephrogenic diabetes insipidus)
Renal tubular acidosis
Nephrotic syndrome

Thyroid dysfunction

Discussion

Despite the potential side-effects, lithium remains a first-line treatment option for BPAD. Patients receiving palliative care may be at increased risk for developing toxicity due to reduced intake, increasing frailty or intercurrent illness. Recognising toxicity is essential to allow for prompt management where appropriate. Differential diagnoses include serotonin syndrome and neuroleptic malignant syndrome.

Conclusion

Lithium toxicity can present with unpleasant, debilitating and potentially life-threatening manifestations. Although there are limitations, it can be managed effectively in an inpatient hospice setting.

Title: Managing Lithium Toxicity in an Inpatient Hospice Setting

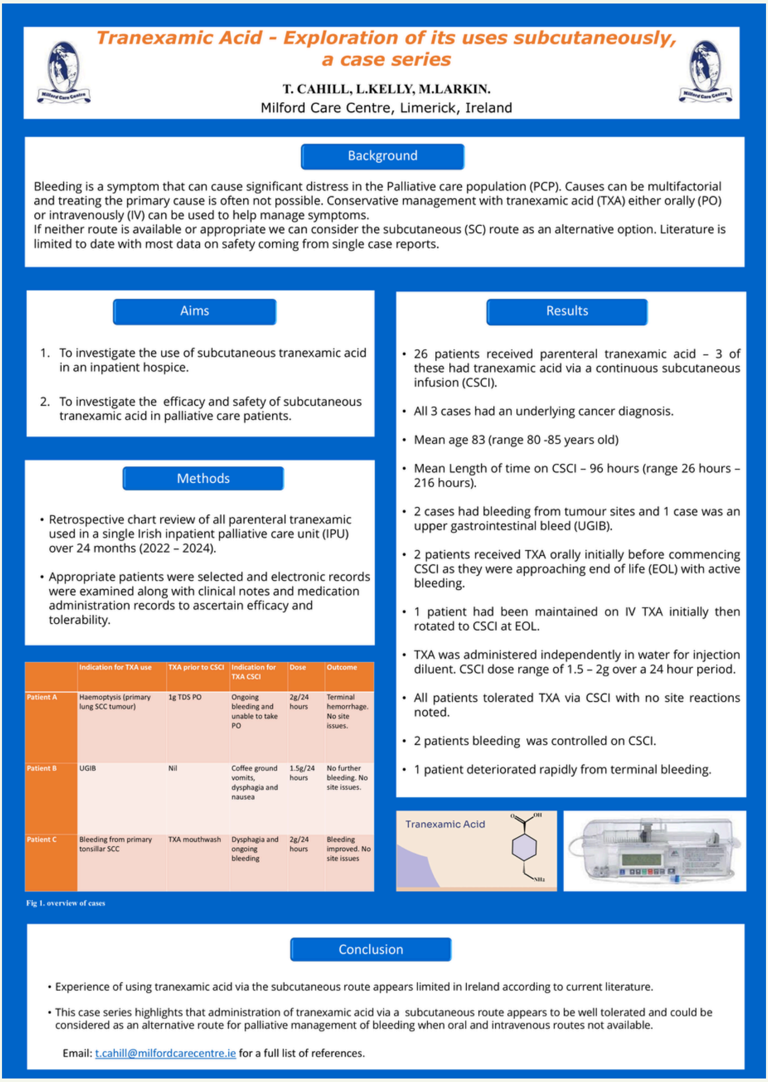
Authors: Ruttledge, Cahill, Twomey

Research

Title: Project on how Out of Hours Communication affects Emergency Department Admissions

Authors: Ong

Research



Tranexamic Acid - Exploration of its uses subcutaneously, a case series

T. CAHILL, L.KELLY, M.LARKIN.
Milford Care Centre, Limerick, Ireland

Background

Bleeding is a symptom that can cause significant distress in the Palliative care population (PCP). Causes can be multifactorial and treating the primary cause is often not possible. Conservative management with tranexamic acid (TXA) either orally (PO) or intravenously (IV) can be used to help manage symptoms.
If neither route is available or appropriate we can consider the subcutaneous (SC) route as an alternative option. Literature is limited to date with most data on safety coming from single case reports.

Aims

1. To investigate the use of subcutaneous tranexamic acid in an inpatient hospice.
2. To investigate the efficacy and safety of subcutaneous tranexamic acid in palliative care patients.

Methods

- Retrospective chart review of all parenteral tranexamic used in a single Irish inpatient palliative care unit (IPU) over 24 months (2022 – 2024).
- Appropriate patients were selected and electronic records were examined along with clinical notes and medication administration records to ascertain efficacy and tolerability.

	Indication for TXA use	TXA prior to CSCI	Indication for TXA CSCI	Dose	Outcome
Patient A	Haemoptysis (primary lung SCC tumour)	1g TDS PO	Ongoing bleeding and unable to take PO	2g/24 hours	Terminal hemorrhage. No site issues.
Patient B	UGIB	Nil	Coffee ground vomits, dysphagia and nausea	1.5g/24 hours	No further bleeding. No site issues.
Patient C	Bleeding from primary tonsillar SCC	TXA mouthwash	Dysphagia and ongoing bleeding	2g/24 hours	Bleeding improved. No site issues

Fig 1. overview of cases

Results

- 26 patients received parenteral tranexamic acid – 3 of these had tranexamic acid via a continuous subcutaneous infusion (CSCI).
- All 3 cases had an underlying cancer diagnosis.
- Mean age 83 (range 80 -85 years old)
- Mean Length of time on CSCI – 96 hours (range 26 hours – 216 hours).
- 2 cases had bleeding from tumour sites and 1 case was an upper gastrointestinal bleed (UGIB).
- 2 patients received TXA orally initially before commencing CSCI as they were approaching end of life (EOL) with active bleeding.
- 1 patient had been maintained on IV TXA initially then rotated to CSCI at EOL.
- TXA was administered independently in water for injection diluent. CSCI dose range of 1.5 – 2g over a 24 hour period.
- All patients tolerated TXA via CSCI with no site reactions noted.
- 2 patients bleeding was controlled on CSCI.
- 1 patient deteriorated rapidly from terminal bleeding.

Conclusion

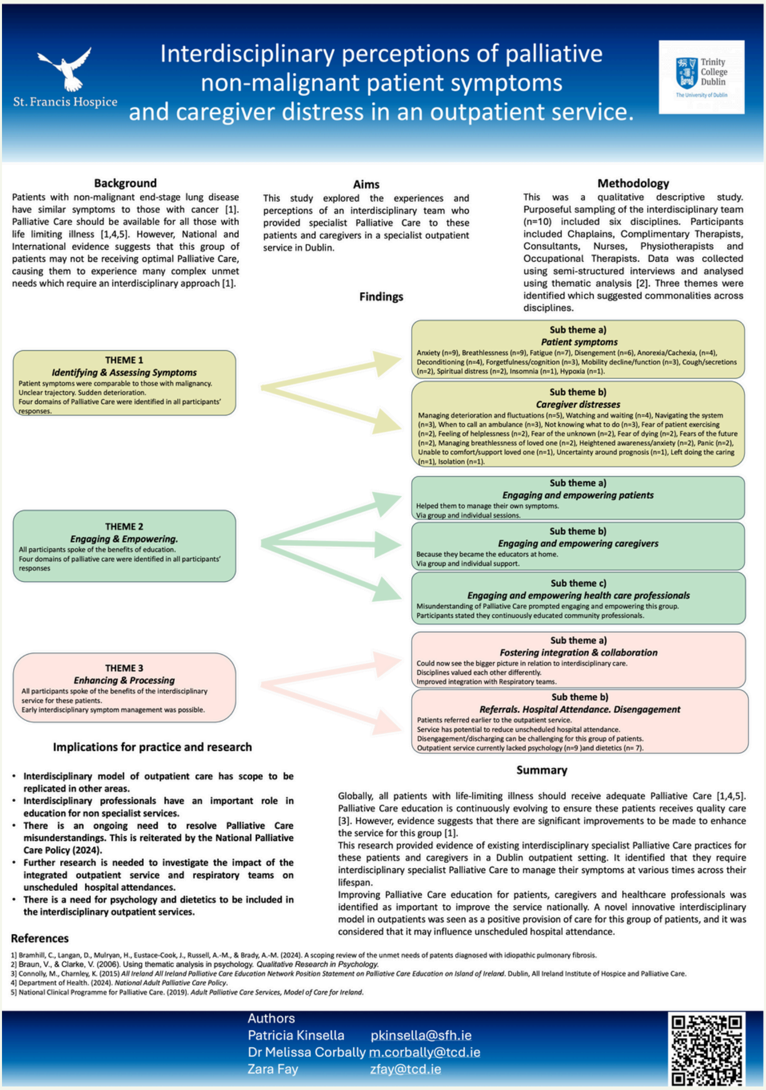
- Experience of using tranexamic acid via the subcutaneous route appears limited in Ireland according to current literature.
- This case series highlights that administration of tranexamic acid via a subcutaneous route appears to be well tolerated and could be considered as an alternative route for palliative management of bleeding when oral and intravenous routes not available.

Email: t.cahill@milfordcarecentre.ie for a full list of references.

Title: Tranexamic Acid - exploration of its use subcutaneously

Authors: Cahill, Kelly, Larkin

Research



Interdisciplinary perceptions of palliative non-malignant patient symptoms and caregiver distress in an outpatient service.

Background

Patients with non-malignant end-stage lung disease have similar symptoms to those with cancer [1]. Palliative Care should be available for all those with life limiting illness [1,4,5]. However, National and International evidence suggests that this group of patients may not be receiving optimal Palliative Care, causing them to experience many complex unmet needs which require an interdisciplinary approach [1].

Aims

This study explored the experiences and perceptions of an interdisciplinary team who provided specialist Palliative Care to these patients and caregivers in a specialist outpatient service in Dublin.

Methodology

This was a qualitative descriptive study. Purposeful sampling of the interdisciplinary team (n=10) included six disciplines. Participants included Chaplains, Complimentary Therapists, Consultants, Nurses, Physiotherapists and Occupational Therapists. Data was collected using semi-structured interviews and analysed using thematic analysis [2]. Three themes were identified which suggested commonalities across disciplines.

Findings

THEME 1
Identifying & Assessing Symptoms
Patient symptoms were comparable to those with malignancy.
Unclear trajectory. Sudden deterioration.
Four domains of Palliative Care were identified in all participants' responses.

Sub theme a)
Patient symptoms
Anxiety (n=9), Breathlessness (n=9), Fatigue (n=7), Disengement (n=6), Anorexia/Cachexia, (n=4), Deconditioning (n=4), Forgetfulness/cognition (n=3), Mobility decline/function (n=3), Cough/secretions (n=2), Spiritual distress (n=2), Insomnia (n=1), Hypoxia (n=1).

Sub theme b)
Caregiver distresses
Managing deterioration and fluctuations (n=5), Watching and waiting (n=4), Navigating the system (n=3), When to call an ambulance (n=3), Not knowing what to do (n=3), Fear of patient exercising (n=2), Feeling of helplessness (n=2), Fear of the unknown (n=2), Fear of dying (n=2), Fears of the future (n=2), Managing breathlessness of loved one (n=2), Heightened awareness/anxiety (n=2), Panic (n=2), Unable to comfort/support loved one (n=1), Uncertainty around prognosis (n=1), Left doing the caring (n=1), Isolation (n=1).

THEME 2
Engaging & Empowering.
All participants spoke of the benefits of education.
Four domains of palliative care were identified in all participants' responses

Sub theme a)
Engaging and empowering patients
Helped them to manage their own symptoms.
Via group and individual sessions.

Sub theme b)
Engaging and empowering caregivers
Because they became the educators at home.
Via group and individual support.

Sub theme c)
Engaging and empowering health care professionals
Misunderstanding of Palliative Care prompted engaging and empowering this group.
Participants stated they continuously educated community professionals.

THEME 3
Enhancing & Processing
All participants spoke of the benefits of the interdisciplinary service for these patients.
Early interdisciplinary symptom management was possible.

Sub theme a)
Fostering integration & collaboration
Could now see the bigger picture in relation to interdisciplinary care.
Disciplines valued each other differently.
Improved integration with Respiratory teams.

Sub theme b)
Referrals. Hospital Attendance. Disengagement
Patients referred earlier to the outpatient service.
Service has potential to reduce unscheduled hospital attendance.
Disengagement/discharging can be challenging for this group of patients.
Outpatient service currently lacked psychology (n=9)and dietetics (n= 7).

Implications for practice and research

- **Interdisciplinary model of outpatient care has scope to be replicated in other areas.**
- **Interdisciplinary professionals have an important role in education for non specialist services.**
- **There is an ongoing need to resolve Palliative Care misunderstandings. This is reiterated by the National Palliative Care Policy (2024).**
- **Further research is needed to investigate the impact of the integrated outpatient service and respiratory teams on unscheduled hospital attendances.**
- **There is a need for psychology and dietetics to be included in the interdisciplinary outpatient services.**

Summary

Globally, all patients with life-limiting illness should receive adequate Palliative Care [1,4,5]. Palliative Care education is continuously evolving to ensure these patients receives quality care [3]. However, evidence suggests that there are significant improvements to be made to enhance the service for this group [1].

This research provided evidence of existing interdisciplinary specialist Palliative Care practices for these patients and caregivers in a Dublin outpatient setting. It identified that they require interdisciplinary specialist Palliative Care to manage their symptoms at various times across their lifespan.

Improving Palliative Care education for patients, caregivers and healthcare professionals was identified as important to improve the service nationally. A novel innovative interdisciplinary model in outpatients was seen as a positive provision of care for this group of patients, and it was considered that it may influence unscheduled hospital attendance.

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Title: Interdisciplinary perceptions of palliative non-malignant patient symptoms and caregiver distress in an outpatient service.

Authors: Kinsella, Corbally

Research

A Clinical Audit of Physiotherapy Documentation within St. Francis Hospice Dublin

Sinead Coyle, Lisa McGirr, Physiotherapy Department St Francis Hospice Dublin

St. Francis Hospice

Background

In March 2020, outpatient clinics were suspended in St Francis Hospice Dublin (SFHD) due to the COVID-19 pandemic. Physiotherapy delivery transitioned to home visits to facilitate essential assessments for SFHD Community Palliative Care (CPC) patients.

The Patient Administration System (PAS) was rolled out across all disciplines within SFHD to ensure up-to-date record-keeping. PAS allowed professionals to document and access patient information electronically when healthcare records were unavailable. An electronic physiotherapy assessment template was developed within PAS to streamline documentation.

Aim

A documentation audit was conducted over a 12-month period:

- ✓ To maximise patient safety
- ✓ To improve quality of care
- ✓ To ensure that standards of documentation within the SFHD physiotherapy team are in line with guidelines from the relevant professional bodies.

Standards

Guidelines and codes of professional conduct from the following professional bodies:

CORU Ag Rialáil Gairmithe Sláinte agus Cúraim Shóisialaigh Regulating Health + Social Care Professionals

Irish Society of Chartered Physiotherapists

HSE Feidhmeannacht na Seirbhíse Sláinte Health Service Executive

St. Francis Hospice

Methodology

- 20 healthcare records - 10 from each site
- Healthcare record from 4 physiotherapists audited
  2-6 charts from each physiotherapist
- Random patient selection
- Records evaluated according to chosen standards
- Results collated and presented

March 2020 – OPD clinics suspended due to the Covid-19 pandemic

May 2020 - PAS system rolled out across all disciplines to facilitate electronic patient record keeping

June 2020 – Electronic Physiotherapy template for PAS developed to streamline documentation

December 2021 - Audit completed and results presented to SFHD physiotherapy team with a focus on 3 action points for re-audit

September 2022 – Reaudit of documentation

Standards Results & Re-Audit of Implemented Recommendations

- There were 11 standards in total with some sub sections
- Each point carried a weighting of 1
  Total = 23 points per patient record

	Audit	Re-Audit
Average Success	85%	94%

Actions taken in preparation for re-audit:

Actions of Investigator	Actions of Physiotherapy Team
Letter to Audit Committee with recommendation that SFHD abbreviations be updated Feedback to Physiotherapy team with action points to improve documentation compliance	Conform to SFHD listed abbreviations Use time in 24 hour format Use of digital signature Educate new staff

Conclusion & Future Implications

- Documentation has improved due to the actions taken to date. To strive for further improvement a re-audit will take place in February 2025
- The investigator will work with the relevant committee to update approved abbreviations within SFHD as this remains a barrier in achieving better success rates.

www.sfh.ie

Title: Physiotherapy Department Documentation Audit

Authors: Coyle, McGirr

Research

GALWAY HOSPICE · MAYO HOSPICE

A Multidisciplinary Collaborative Quality Improvement Initiative to reduce *Falls* and minimise associated harm in a Hospice Inpatient Setting

Authors: *J. Boult[1], J. Brennock[2], V. Butler[3], M. Carr[4], D. Lynott[5], N. McKeon[6], M. Murrihy[7], M. Scarry[8]*

Falls are a commonly reported safety incident in Specialist Palliative Care Inpatient settings in Ireland. The risk factors are multifaceted and frequently interlinked with underpinning complex mechanisms including history of falls, age of the person, impact of complex medications, functional status and presence of delirium. The national benchmark in Specialist Palliative Care in Ireland is less than 12 falls per 1000 occupied bed days. While Galway and Mayo Hospice have routinely met this target, a multidisciplinary and multi-faceted approach has been taken since 2021 to reduce the risk further and to minimise the potential for injury.

MULTIFACETED APPROACH:

All patients screened for falls	A Footwear First campaign and easy-read falls prevention leaflet for patients and their families.
Standardised the multi-factorial falls assessment tool.	Regular falls tracer audits including staff and patient interviews.
Review of the individual falls care plan	All slips/ trips/ falls incidents and near-miss incidents are reported and investigated using a corrective action, route cause and preventative action approach.
Optimising of management tools: supervision, equipment, alarms, mobility aids and environment.	A Consultant led Multidisciplinary Falls Working Group developed
Daily safety pause as a communication channel for raising awareness of a patient's falls risk.	Contributed towards the development of a performance indicator for falls that can be benchmarked across the sector.
Falls risk identifier on the electronic healthcare record and displayed on the electronic dashboard	Falls data: o Discussed quarterly at the Quality and Patient Safety Committee of the Hospice Board o Circulated to staff o Published on the Hospice website annually.
MDT education and initiatives to raise awareness including falls awareness week.	

MULTIDISCIPLINARY AND COLLABORATIVE APPROACH:

DRIVE
Quality and Patient Safety Committee of the Board

SUPPORT
Executive Team Members: CEO, Director of Nursing and Therapy Services, Clinical Director, Director of Quality

IMPLEMENT
ALL STAFF

Review, Audit, Measure, Feedback, Optimise

Medical · **Nursing** · **Occupational Therapy** · **Nursing Practice Education** · **Patient Family Communities** · **Maintenance/ Facilities** · **Physiotherapy** · **Quality** · **Pharmacy**

RESULTS:

Number of patient falls Inpatient Unit per 1000 occupied bed days	2022	2023	2024 Q1 & Q2
GALWAY	7.0	5.4	5.4
MAYO	6.5	4.6	3.2

"In addition to the reduction in falls, I have observed a noticeable increase in awareness of falls prevention and management, and in proactive engagement by all members of the team in implementing measures to support patient safety around falls"

Clinical Nurse Manager, Inpatient Unit

DISCUSSION:

Multidisciplinary quality initiatives and interventions in recent years have resulted in a sustained decrease in the number of falls per 1000 occupied bed days, and in ensuring that no falls resulting in injury have occurred in 2023 or to date in 2024.

While acknowledging the resources required to plan, drive and implement these quality improvements operationally, positive feedback has been received consistently from staff, management and the Quality and Patient Safety Committee as to the impact on patient safety.

FUTURE DISCUSSION:

- **Patient Engagement:**
  Increase the opportunity for the patient voice in Falls prevention and management through ongoing involvement of the Hospice Patient Engagement Committee.
- **Sustain and Build:**
  The Multidisciplinary Falls Working Group aims to sustain and build on the improvements in the prevention and management of falls that have taken place across the organisation.
- **Collaborate and Share:**
  The interventions in this initiative are transferrable across specialist palliative care Inpatient settings nationally and could support the reduction of falls and the resulting harm to patients.

1: Therapies Manager, 2: Consultant in Palliative Medicine, 3: Quality Assurance Co-ordinator, 4: Director of Nursing and Therapy Services, 5: Assistant Director of Nursing, 6: Director of Quality, 7 Acting Head of Quality, 8: Quality Assurance Co-ordinator

Title: A multidisciplinary collaborative quality improvement initiative to reduce falls and minimise associated harm in a Hospice inpatient setting

Authors: Brennock, Boult, Butler, Carr, Lynott, McKeon, Murrihy, Scarry, Healy

Research

End-of-life care decision-making: Barriers and facilitators for healthcare professionals in specialist palliative care

Dr. Hannah Featherstone [1,2], Dr. Regina McQuillan [2,3], Dr. Geraldine Foley [1].
1. Trinity College Dublin 2. St Francis Hospice, Dublin. 3. Beaumont Hospital, Dublin

Background

- Healthcare professionals in specialist palliative care assume responsibility to advise patients and their family caregivers about what treatments and supportive care are available to and suitable for the patient during end-of-life care (1).
- What enables and/or restricts healthcare professionals in specialist palliative care to be effective in this role and support the patient and family caregiver in decision-making is not fully understood.

Aims and Objectives

- To identify barriers and facilitators for healthcare professionals in specialist palliative care with respect to supporting patients and family caregivers in the decision-making process for patient end-of-life care.

Methods

Qualitative study

22 healthcare professionals: (n=4 physicians, n=4 allied health professionals, and n=14 nurses)

Recruited from a large regional specialist palliative care service in Ireland (catchment of 15% of national population).

Data collection in five focus groups.

All focus groups member checked and transcribed.

Data analysed using reflexive thematic analysis (2).

Findings

Facilitators to supporting end-of-life decision making in specialist palliative care

- ✓ Open and trusted communication with healthcare professionals
- ✓ Early but phased discussions about the patient's preferences for end-of-life care
- ✓ Expertise gained from prior end-of-life care discussions
- ✓ Prioritisation of end-of-life discussions over other clinical duties when needed

Barriers to supporting end-of-life decision making in specialist palliative care

- ✕ Family caregivers' overestimation of their decision-making remit
- ✕ Family caregivers' desire to conceal information from the patient
- ✕ Lack of input from other specialties in end-of-life discussions
- ✕ Prognostic uncertainty on behalf of patient and healthcare professional

Conclusion

End-of-life care decision-making with patients and family caregivers was a key feature of work for specialist palliative care healthcare professionals and participants felt they had an optimal approach to providing support.

Open communication helps specialist palliative care healthcare professionals ensure that patient autonomy remains central in the decision-making process for end-of-life care.

Early involvement of specialist palliative care for timely exploration of preferences for end-of-life care and continuity of care aids with establishing a trusting relationship with patients and family caregivers.

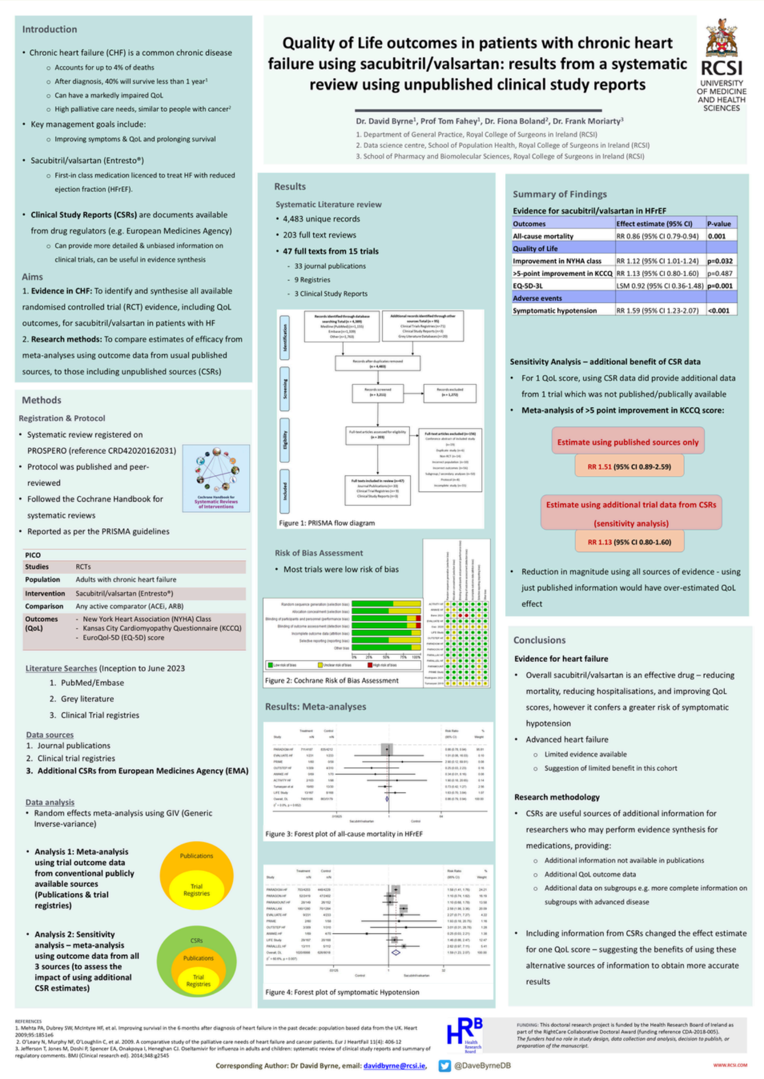
References:

sfh.ie

Title: End-of-life care decision-making: Barriers and facilitators for healthcare professionals in specialist palliative care

Authors: Featherstone, McQuillan, Foley

Research



Quality of Life outcomes in patients with chronic heart failure using sacubitril/valsartan: results from a systematic review using unpublished clinical study reports

Dr. David Byrne[1], Prof Tom Fahey[1], Dr. Fiona Boland[2], Dr. Frank Moriarty[3]

1. Department of General Practice, Royal College of Surgeons in Ireland (RCSI)
2. Data science centre, School of Population Health, Royal College of Surgeons in Ireland (RCSI)
3. School of Pharmacy and Biomolecular Sciences, Royal College of Surgeons in Ireland (RCSI)

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Introduction

- Chronic heart failure (CHF) is a common chronic disease
  - Accounts for up to 4% of deaths
  - After diagnosis, 40% will survive less than 1 year[1]
  - Can have a markedly impaired QoL
  - High palliative care needs, similar to people with cancer[2]
- Key management goals include:
  - Improving symptoms & QoL and prolonging survival
- Sacubitril/valsartan (Entresto®)
  - First-in class medication licenced to treat HF with reduced ejection fraction (HFrEF).
- **Clinical Study Reports (CSRs)** are documents available from drug regulators (e.g. European Medicines Agency)
  - Can provide more detailed & unbiased information on clinical trials, can be useful in evidence synthesis

Aims

1. **Evidence in CHF:** To identify and synthesise all available randomised controlled trial (RCT) evidence, including QoL outcomes, for sacubitril/valsartan in patients with HF
2. **Research methods:** To compare estimates of efficacy from meta-analyses using outcome data from usual published sources, to those including unpublished sources (CSRs)

Methods

Registration & Protocol

- Systematic review registered on PROSPERO (reference CRD42020162031)
- Protocol was published and peer-reviewed
- Followed the Cochrane Handbook for systematic reviews
- Reported as per the PRISMA guidelines

Cochrane Handbook for Systematic Reviews of Interventions

PICO	
Studies	RCTs
Population	Adults with chronic heart failure
Intervention	Sacubitril/valsartan (Entresto®)
Comparison	Any active comparator (ACEi, ARB)
Outcomes (QoL)	- New York Heart Association (NYHA) Class - Kansas City Cardiomyopathy Questionnaire (KCCQ) - EuroQol-5D (EQ-5D) score

Literature Searches (Inception to June 2023

1. PubMed/Embase
2. Grey literature
3. Clinical Trial registries

Data sources

1. Journal publications
2. Clinical trial registries
3. **Additional CSRs from European Medicines Agency (EMA)**

Data analysis

- Random effects meta-analysis using GIV (Generic Inverse-variance)
- **Analysis 1: Meta-analysis using trial outcome data from conventional publicly available sources (Publications & trial registries)**
- **Analysis 2: Sensitivity analysis – meta-analysis using outcome data from all 3 sources (to assess the impact of using additional CSR estimates)**

Results

Systematic Literature review

- 4,483 unique records
- 203 full text reviews
- **47 full texts from 15 trials**
  - 33 journal publications
  - 9 Registries
  - 3 Clinical Study Reports

Figure 1: PRISMA flow diagram

Risk of Bias Assessment

- Most trials were low risk of bias

Figure 2: Cochrane Risk of Bias Assessment

Results: Meta-analyses

Figure 3: Forest plot of all-cause mortality in HFrEF

Figure 4: Forest plot of symptomatic Hypotension

Summary of Findings

Evidence for sacubitril/valsartan in HFrEF

Outcomes	Effect estimate (95% CI)	P-value
All-cause mortality	RR 0.86 (95% CI 0.79-0.94)	**0.001**
Quality of Life		
Improvement in NYHA class	RR 1.12 (95% CI 1.01-1.24)	**p=0.032**
>5-point improvement in KCCQ	RR 1.13 (95% CI 0.80-1.60)	p=0.487
EQ-5D-3L	LSM 0.92 (95% CI 0.36-1.48)	**p=0.001**
Adverse events		
Symptomatic hypotension	RR 1.59 (95% CI 1.23-2.07)	**<0.001**

Sensitivity Analysis – additional benefit of CSR data

- For 1 QoL score, using CSR data did provide additional data from 1 trial which was not published/publically available
- **Meta-analysis of >5 point improvement in KCCQ score:**

Estimate using published sources only

RR 1.51 (95% CI 0.89-2.59)

Estimate using additional trial data from CSRs (sensitivity analysis)

RR 1.13 (95% CI 0.80-1.60)

- Reduction in magnitude using all sources of evidence - using just published information would have over-estimated QoL effect

Conclusions

Evidence for heart failure

- Overall sacubitril/valsartan is an effective drug – reducing mortality, reducing hospitalisations, and improving QoL scores, however it confers a greater risk of symptomatic hypotension
- Advanced heart failure
  - Limited evidence available
  - Suggestion of limited benefit in this cohort

Research methodology

- CSRs are useful sources of additional information for researchers who may perform evidence synthesis for medications, providing:
  - Additional information not available in publications
  - Additional QoL outcome data
  - Additional data on subgroups e.g. more complete information on subgroups with advanced disease
- Including information from CSRs changed the effect estimate for one QoL score – suggesting the benefits of using these alternative sources of information to obtain more accurate results

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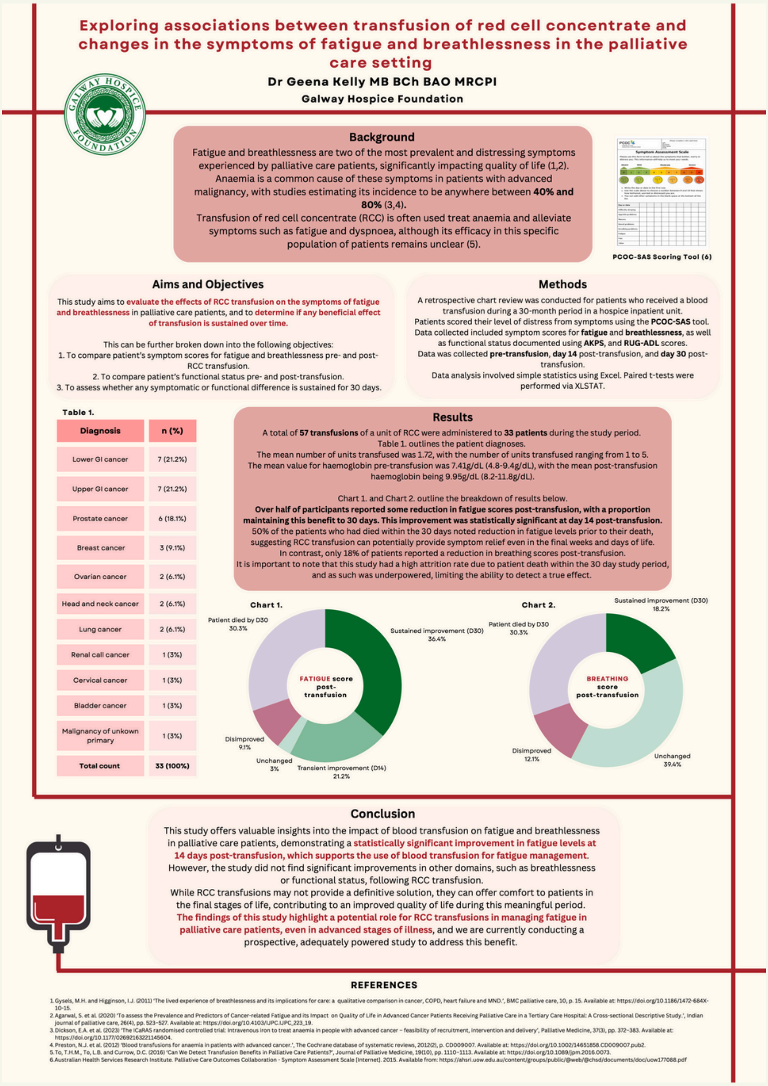
Title: Quality of Life outcomes in patients with chronic heart failure using sacubitril/valsartan: results from a systematic review

Authors: Byrne, Fahey, Moriarty

Research



Exploring associations between transfusion of red cell concentrate and changes in the symptoms of fatigue and breathlessness in the palliative care setting

Dr Geena Kelly MB BCh BAO MRCPI

Galway Hospice Foundation

Background

Fatigue and breathlessness are two of the most prevalent and distressing symptoms experienced by palliative care patients, significantly impacting quality of life (1,2). Anaemia is a common cause of these symptoms in patients with advanced malignancy, with studies estimating its incidence to be anywhere between **40% and 80%** (3,4).

Transfusion of red cell concentrate (RCC) is often used treat anaemia and alleviate symptoms such as fatigue and dyspnoea, although its efficacy in this specific population of patients remains unclear (5).

PCOC-SAS Scoring Tool (6)

Aims and Objectives

This study aims to **evaluate the effects of RCC transfusion on the symptoms of fatigue and breathlessness** in palliative care patients, and to **determine if any beneficial effect of transfusion is sustained over time.**

This can be further broken down into the following objectives:

1. To compare patient's symptom scores for fatigue and breathlessness pre- and post-RCC transfusion.
2. To compare patient's functional status pre- and post-transfusion.
3. To assess whether any symptomatic or functional difference is sustained for 30 days.

Methods

A retrospective chart review was conducted for patients who received a blood transfusion during a 30-month period in a hospice inpatient unit.

Patients scored their level of distress from symptoms using the **PCOC-SAS** tool.

Data collected included symptom scores for **fatigue** and **breathlessness**, as well as functional status documented using **AKPS**, and **RUG-ADL** scores.

Data was collected **pre-transfusion**, **day 14** post-transfusion, and **day 30** post-transfusion.

Data analysis involved simple statistics using Excel. Paired t-tests were performed via XLSTAT.

Table 1.

Diagnosis	n (%)
Lower GI cancer	7 (21.2%)
Upper GI cancer	7 (21.2%)
Prostate cancer	6 (18.1%)
Breast cancer	3 (9.1%)
Ovarian cancer	2 (6.1%)
Head and neck cancer	2 (6.1%)
Lung cancer	2 (6.1%)
Renal call cancer	1 (3%)
Cervical cancer	1 (3%)
Bladder cancer	1 (3%)
Malignancy of unkown primary	1 (3%)
Total count	**33 (100%)**

Results

A total of **57 transfusions** of a unit of RCC were administered to **33 patients** during the study period.

Table 1. outlines the patient diagnoses.

The mean number of units transfused was 1.72, with the number of units transfused ranging from 1 to 5.

The mean value for haemoglobin pre-transfusion was 7.41g/dL (4.8-9.4g/dL), with the mean post-transfusion haemoglobin being 9.95g/dL (8.2-11.8g/dL).

Chart 1. and Chart 2. outline the breakdown of results below.

Over half of participants reported some reduction in fatigue scores post-transfusion, with a proportion maintaining this benefit to 30 days. This improvement was statistically significant at day 14 post-transfusion.

50% of the patients who had died within the 30 days noted reduction in fatigue levels prior to their death, suggesting RCC transfusion can potentially provide symptom relief even in the final weeks and days of life.

In contrast, only 18% of patients reported a reduction in breathing scores post-transfusion.

It is important to note that this study had a high attrition rate due to patient death within the 30 day study period, and as such was underpowered, limiting the ability to detect a true effect.

Chart 1.

Chart 2.

Conclusion

This study offers valuable insights into the impact of blood transfusion on fatigue and breathlessness in palliative care patients, demonstrating a **statistically significant improvement in fatigue levels at 14 days post-transfusion, which supports the use of blood transfusion for fatigue management**.

However, the study did not find significant improvements in other domains, such as breathlessness or functional status, following RCC transfusion.

While RCC transfusions may not provide a definitive solution, they can offer comfort to patients in the final stages of life, contributing to an improved quality of life during this meaningful period.

The findings of this study highlight a potential role for RCC transfusions in managing fatigue in palliative care patients, even in advanced stages of illness, and we are currently conducting a prospective, adequately powered study to address this benefit.

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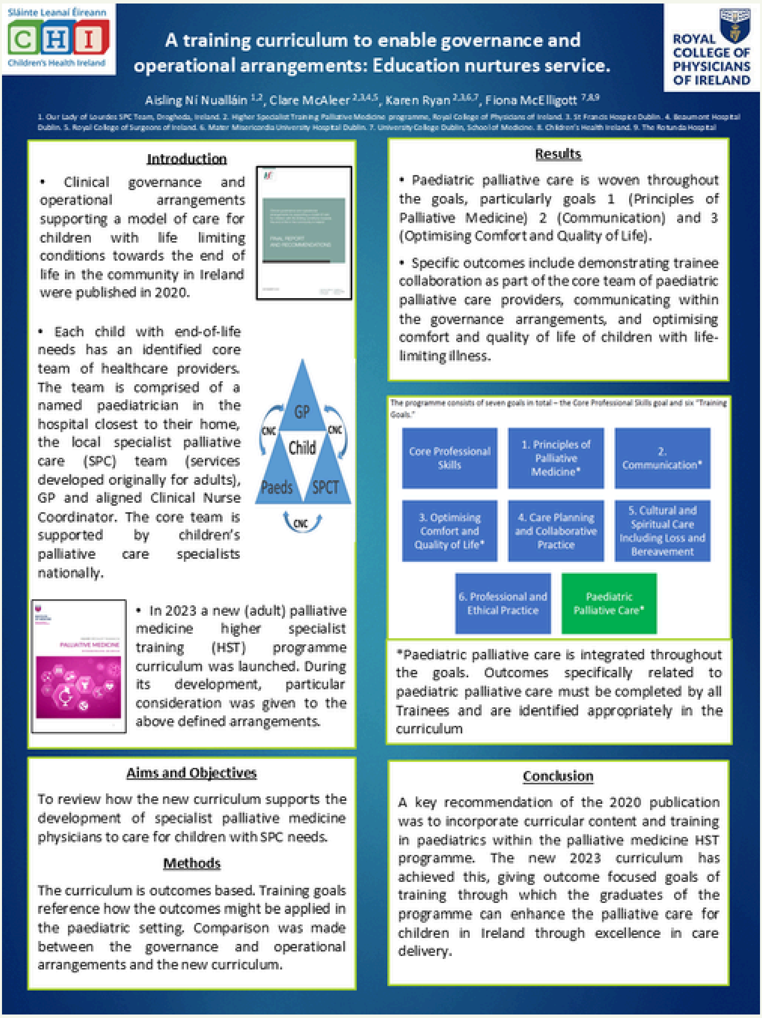
Title: The impact of blood transfusion on fatigue and breathlessness in the palliative care setting

Authors: Kelly, Kruger

Research



A training curriculum to enable governance and operational arrangements: Education nurtures service.

Aisling Ni Nualláin [1,2], Clare McAleer [2,3,4,5], Karen Ryan [2,3,6,7], Fiona McElligott [7,8,9]

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Introduction

- Clinical governance and operational arrangements supporting a model of care for children with life limiting conditions towards the end of life in the community in Ireland were published in 2020.
- Each child with end-of-life needs has an identified core team of healthcare providers. The team is comprised of a named paediatrician in the hospital closest to their home, the local specialist palliative care (SPC) team (services developed originally for adults), GP and aligned Clinical Nurse Coordinator. The core team is supported by children's palliative care specialists nationally.
- In 2023 a new (adult) palliative medicine higher specialist training (HST) programme curriculum was launched. During its development, particular consideration was given to the above defined arrangements.

Aims and Objectives

To review how the new curriculum supports the development of specialist palliative medicine physicians to care for children with SPC needs.

Methods

The curriculum is outcomes based. Training goals reference how the outcomes might be applied in the paediatric setting. Comparison was made between the governance and operational arrangements and the new curriculum.

Results

- Paediatric palliative care is woven throughout the goals, particularly goals 1 (Principles of Palliative Medicine) 2 (Communication) and 3 (Optimising Comfort and Quality of Life).
- Specific outcomes include demonstrating trainee collaboration as part of the core team of paediatric palliative care providers, communicating within the governance arrangements, and optimising comfort and quality of life of children with life-limiting illness.

The programme consists of seven goals in total – the Core Professional Skills goal and six "Training Goals."

Core Professional Skills
1. Principles of Palliative Medicine*
2. Communication*
3. Optimising Comfort and Quality of Life*
4. Care Planning and Collaborative Practice
5. Cultural and Spiritual Care Including Loss and Bereavement
6. Professional and Ethical Practice
Paediatric Palliative Care*

*Paediatric palliative care is integrated throughout the goals. Outcomes specifically related to paediatric palliative care must be completed by all Trainees and are identified appropriately in the curriculum

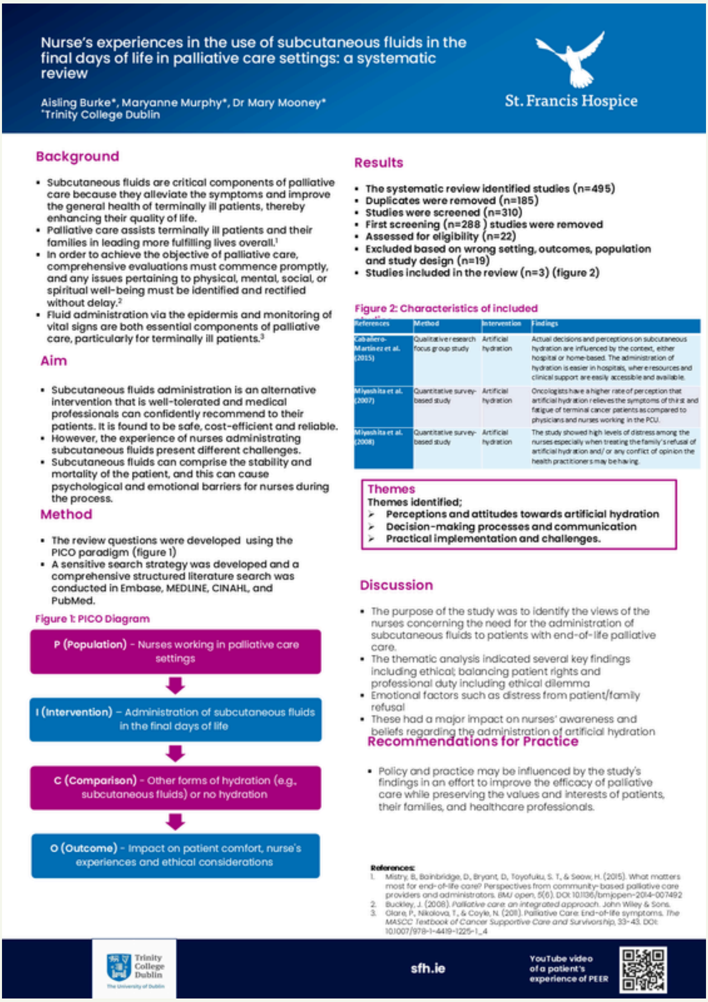
Conclusion

A key recommendation of the 2020 publication was to incorporate curricular content and training in paediatrics within the palliative medicine HST programme. The new 2023 curriculum has achieved this, giving outcome focused goals of training through which the graduates of the programme can enhance the palliative care for children in Ireland through excellence in care delivery.

Title: A training curriculum to enable governance and operational arrangements: Education nurtures service.

Authors: Ni Nuallain, McAleer, Ryan, McElligot

Research



Nurse's experiences in the use of subcutaneous fluids in the final days of life in palliative care settings: a systematic review

Aisling Burke*, Maryanne Murphy*, Dr Mary Mooney*
*Trinity College Dublin

St. Francis Hospice

Background

- Subcutaneous fluids are critical components of palliative care because they alleviate the symptoms and improve the general health of terminally ill patients, thereby enhancing their quality of life.
- Palliative care assists terminally ill patients and their families in leading more fulfilling lives overall.[1]
- In order to achieve the objective of palliative care, comprehensive evaluations must commence promptly, and any issues pertaining to physical, mental, social, or spiritual well-being must be identified and rectified without delay.[2]
- Fluid administration via the epidermis and monitoring of vital signs are both essential components of palliative care, particularly for terminally ill patients.[3]

Aim

- Subcutaneous fluids administration is an alternative intervention that is well-tolerated and medical professionals can confidently recommend to their patients. It is found to be safe, cost-efficient and reliable.
- However, the experience of nurses administrating subcutaneous fluids present different challenges.
- Subcutaneous fluids can comprise the stability and mortality of the patient, and this can cause psychological and emotional barriers for nurses during the process.

Method

- The review questions were developed using the PICO paradigm (figure 1)
- A sensitive search strategy was developed and a comprehensive structured literature search was conducted in Embase, MEDLINE, CINAHL, and PubMed.

Figure 1: PICO Diagram

P (Population) – Nurses working in palliative care settings

I (Intervention) – Administration of subcutaneous fluids in the final days of life

C (Comparison) – Other forms of hydration (e.g. subcutaneous fluids) or no hydration

O (Outcome) – Impact on patient comfort, nurse's experiences and ethical considerations

Results

- The systematic review identified studies (n=495)
- Duplicates were removed (n=185)
- Studies were screened (n=310)
- First screening (n=288) studies were removed
- Assessed for eligibility (n=22)
- Excluded based on wrong setting, outcomes, population and study design (n=19)
- Studies included in the review (n=3) (figure 2)

Figure 2: Characteristics of included

References	Method	Intervention	Findings
Caballero-Martinez et al. (2015)	Qualitative research focus group study	Artificial hydration	Actual decisions and perceptions on subcutaneous hydration are influenced by the context, either hospital or home-based. The administration of hydration is easier in hospitals, where resources and clinical support are easily accessible and available.
Miyashita et al. (2007)	Quantitative survey-based study	Artificial hydration	Oncologists have a higher rate of perception that artificial hydration relieves the symptoms of thirst and fatigue of terminal cancer patients as compared to physicians and nurses working in the PCU.
Miyashita et al. (2008)	Quantitative survey-based study	Artificial hydration	The study showed high levels of distress among the nurses especially when treating the family's refusal of artificial hydration and/ or any conflict of opinion the health practitioners may be having.

Themes

Themes identified;

- **Perceptions and attitudes towards artificial hydration**
- **Decision-making processes and communication**
- **Practical implementation and challenges.**

Discussion

- The purpose of the study was to identify the views of the nurses concerning the need for the administration of subcutaneous fluids to patients with end-of-life palliative care.
- The thematic analysis indicated several key findings including ethical; balancing patient rights and professional duty including ethical dilemma
- Emotional factors such as distress from patient/family refusal
- These had a major impact on nurses' awareness and beliefs regarding the administration of artificial hydration

Recommendations for Practice

- Policy and practice may be influenced by the study's findings in an effort to improve the efficacy of palliative care while preserving the values and interests of patients, their families, and healthcare professionals.

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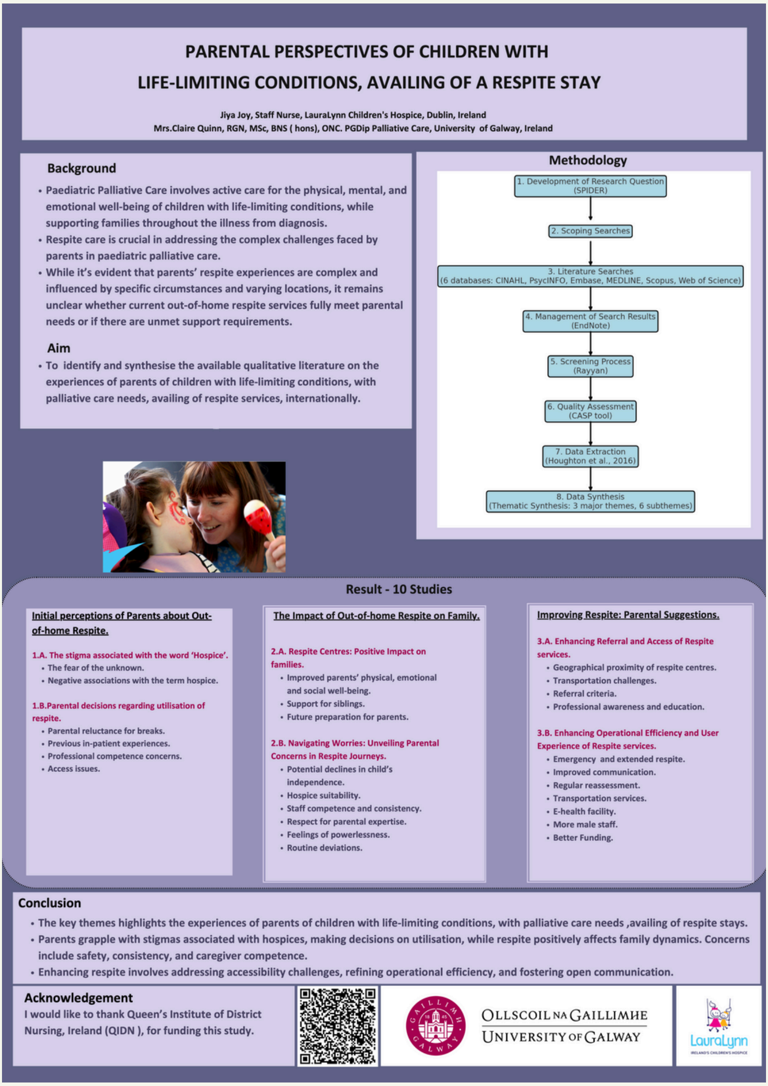
YouTube video of a patient's experience of PEER

Title: Nurse's experiences in the use of subcutaneous fluids in the final days of life in palliative care settings: a systematic review

Authors: Burke

Research



PARENTAL PERSPECTIVES OF CHILDREN WITH LIFE-LIMITING CONDITIONS, AVAILING OF A RESPITE STAY

Jiya Joy, Staff Nurse, LauraLynn Children's Hospice, Dublin, Ireland
Mrs.Claire Quinn, RGN, MSc, BNS (hons), ONC. PGDip Palliative Care, University of Galway, Ireland

Background

- Paediatric Palliative Care involves active care for the physical, mental, and emotional well-being of children with life-limiting conditions, while supporting families throughout the illness from diagnosis.
- Respite care is crucial in addressing the complex challenges faced by parents in paediatric palliative care.
- While it's evident that parents' respite experiences are complex and influenced by specific circumstances and varying locations, it remains unclear whether current out-of-home respite services fully meet parental needs or if there are unmet support requirements.

Aim

- To identify and synthesise the available qualitative literature on the experiences of parents of children with life-limiting conditions, with palliative care needs, availing of respite services, internationally.

Methodology

1. Development of Research Question (SPIDER)
2. Scoping Searches
3. Literature Searches (6 databases: CINAHL, PsycINFO, Embase, MEDLINE, Scopus, Web of Science)
4. Management of Search Results (EndNote)
5. Screening Process (Rayyan)
6. Quality Assessment (CASP tool)
7. Data Extraction (Houghton et al., 2016)
8. Data Synthesis (Thematic Synthesis: 3 major themes, 6 subthemes)

Result - 10 Studies

Initial perceptions of Parents about Out-of-home Respite.

1.A. The stigma associated with the word 'Hospice'.
- The fear of the unknown.
- Negative associations with the term hospice.

1.B.Parental decisions regarding utilisation of respite.
- Parental reluctance for breaks.
- Previous in-patient experiences.
- Professional competence concerns.
- Access issues.

The Impact of Out-of-home Respite on Family.

2.A. Respite Centres: Positive Impact on families.
- Improved parents' physical, emotional and social well-being.
- Support for siblings.
- Future preparation for parents.

2.B. Navigating Worries: Unveiling Parental Concerns in Respite Journeys.
- Potential declines in child's independence.
- Hospice suitability.
- Staff competence and consistency.
- Respect for parental expertise.
- Feelings of powerlessness.
- Routine deviations.

Improving Respite: Parental Suggestions.

3.A. Enhancing Referral and Access of Respite services.
- Geographical proximity of respite centres.
- Transportation challenges.
- Referral criteria.
- Professional awareness and education.

3.B. Enhancing Operational Efficiency and User Experience of Respite services.
- Emergency and extended respite.
- Improved communication.
- Regular reassessment.
- Transportation services.
- E-health facility.
- More male staff.
- Better Funding.

Conclusion

- The key themes highlights the experiences of parents of children with life-limiting conditions, with palliative care needs ,availing of respite stays.
- Parents grapple with stigmas associated with hospices, making decisions on utilisation, while respite positively affects family dynamics. Concerns include safety, consistency, and caregiver competence.
- Enhancing respite involves addressing accessibility challenges, refining operational efficiency, and fostering open communication.

Acknowledgement
I would like to thank Queen's Institute of District Nursing, Ireland (QIDN), for funding this study.

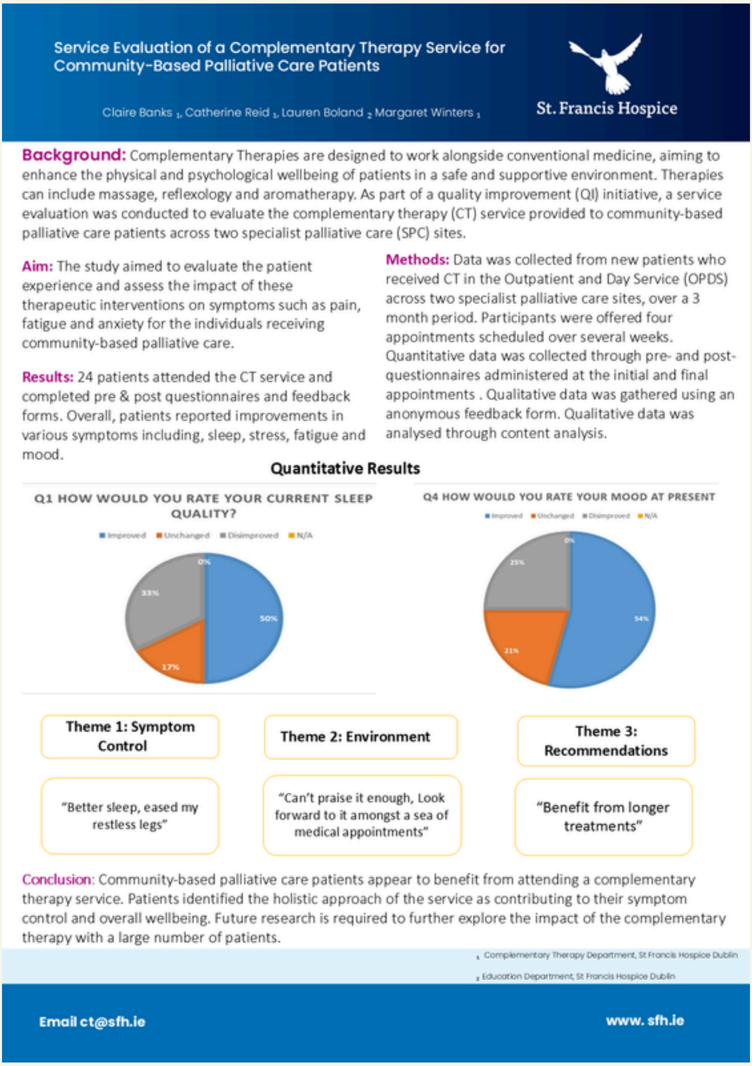
Ollscoil na Gaillimhe
University of Galway

LauraLynn
Ireland's Children's Hospice

Title: Parental perspective of children with life-limiting conditions availing of a Respite Stay

Authors: Joy, Quinn

Research



Service Evaluation of a Complementary Therapy Service for Community-Based Palliative Care Patients

Claire Banks [1], Catherine Reid [1], Lauren Boland [2] Margaret Winters [1]

St. Francis Hospice

Background: Complementary Therapies are designed to work alongside conventional medicine, aiming to enhance the physical and psychological wellbeing of patients in a safe and supportive environment. Therapies can include massage, reflexology and aromatherapy. As part of a quality improvement (QI) initiative, a service evaluation was conducted to evaluate the complementary therapy (CT) service provided to community-based palliative care patients across two specialist palliative care (SPC) sites.

Aim: The study aimed to evaluate the patient experience and assess the impact of these therapeutic interventions on symptoms such as pain, fatigue and anxiety for the individuals receiving community-based palliative care.

Results: 24 patients attended the CT service and completed pre & post questionnaires and feedback forms. Overall, patients reported improvements in various symptoms including, sleep, stress, fatigue and mood.

Methods: Data was collected from new patients who received CT in the Outpatient and Day Service (OPDS) across two specialist palliative care sites, over a 3 month period. Participants were offered four appointments scheduled over several weeks. Quantitative data was collected through pre- and post-questionnaires administered at the initial and final appointments . Qualitative data was gathered using an anonymous feedback form. Qualitative data was analysed through content analysis.

Quantitative Results

Theme 1: Symptom Control	Theme 2: Environment	Theme 3: Recommendations
"Better sleep, eased my restless legs"	"Can't praise it enough, Look forward to it amongst a sea of medical appointments"	"Benefit from longer treatments"

Conclusion: Community-based palliative care patients appear to benefit from attending a complementary therapy service. Patients identified the holistic approach of the service as contributing to their symptom control and overall wellbeing. Future research is required to further explore the impact of the complementary therapy with a large number of patients.

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Title: Service Evaluation of a Complementary Therapy Service for Community-Based Palliative Care Patients

Authors: Banks, Reid, Boland, Winters

Research

Ulster University

HSC Northern Health and Social Care Trust

A Qualitative exploration of Motor Neurone Disease family caregivers' experiences of thepalliative care keyworker

by Maria Betts *(University of Ulster)*; Felicity Hasson *(University of Ulster)*

BACKGROUND

In palliative care the district nurse is the keyworker who is responsible for navigating patients and their families to receive support, information, and continuity of care throughout their journey. A review of the evidence uncovered a dearth of research exploring family caregivers' views of this role across diseases pathways, including Motor Neurone Disease.

AIMS AND OBJECTIVES

To explore the experience of family caregivers (active and bereaved) of patients with MND of the palliative care key worker.

METHODS

An exploratory qualitative research design, comprising of one-to-one in-depth interviews with a purposive sample of six family caregivers was undertaken recruited via Motor Neurone Disease UK.

Interviews were recorded and subject thematic analysis.

FINDINGS/RESULTS

Carers recognised the value of the role, providing personalised care management and coordination, which aided in the seamless delivery of care at the end of life to the MND patient and wider family.

It was identified they not only helped to navigate complex health care systems but tailored education on MND, and support across financial, legal and social issues.

However, it was recognised that the implementation and access to the role was unstandardized. Carers were aware that district nurses assumed this role while balancing heavy caseloads and had limited time to deliver care.

CONCLUSION(S)

Findings suggest that caregivers caring for someone with Motor Neurone Disease patient often feel overwhelmed, yet the key worker role was seen as a source of constant support.

However, its implementation is heterogeneous. Further research is warranted into how to the keyworker can be supported to facilitate more convenient and integrated care and improving access support for caregivers.

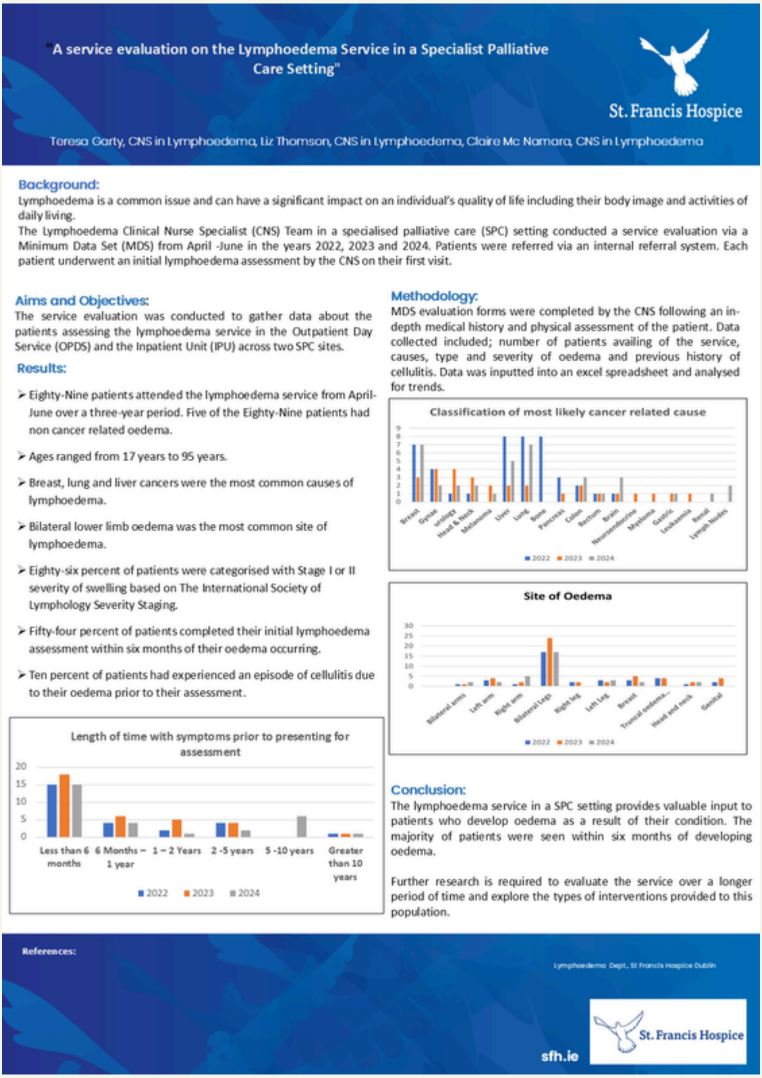
mnda
motor neurone disease
association

Ethics was obtained from University of Ulster ethics committee and Motor Neurone Disease Association acted as gatekeepers for participants.
No funding was sourced for this study and there are no conflicts of interest.

Title: To explore the experience of family caregivers of people with Motor neurone Disease of the palliative care keyworker

Authors: Betts, Hasson

Research



"A service evaluation on the Lymphoedema Service in a Specialist Palliative Care Setting"

St. Francis Hospice

Teresa Garty, CNS in Lymphoedema, Liz Thomson, CNS in Lymphoedema, Claire Mc Namara, CNS in Lymphoedema

Background:

Lymphoedema is a common issue and can have a significant impact on an individual's quality of life including their body image and activities of daily living.

The Lymphoedema Clinical Nurse Specialist (CNS) Team in a specialised palliative care (SPC) setting conducted a service evaluation via a Minimum Data Set (MDS) from April -June in the years 2022, 2023 and 2024. Patients were referred via an internal referral system. Each patient underwent an initial lymphoedema assessment by the CNS on their first visit.

Aims and Objectives:

The service evaluation was conducted to gather data about the patients assessing the lymphoedema service in the Outpatient Day Service (OPDS) and the Inpatient Unit (IPU) across two SPC sites.

Results:

- Eighty-Nine patients attended the lymphoedema service from April-June over a three-year period. Five of the Eighty-Nine patients had non cancer related oedema.
- Ages ranged from 17 years to 95 years.
- Breast, lung and liver cancers were the most common causes of lymphoedema.
- Bilateral lower limb oedema was the most common site of lymphoedema.
- Eighty-six percent of patients were categorised with Stage I or II severity of swelling based on The International Society of Lymphology Severity Staging.
- Fifty-four percent of patients completed their initial lymphoedema assessment within six months of their oedema occurring.
- Ten percent of patients had experienced an episode of cellulitis due to their oedema prior to their assessment.

Length of time with symptoms prior to presenting for assessment

Methodology:

MDS evaluation forms were completed by the CNS following an in-depth medical history and physical assessment of the patient. Data collected included; number of patients availing of the service, causes, type and severity of oedema and previous history of cellulitis. Data was inputted into an excel spreadsheet and analysed for trends.

Classification of most likely cancer related cause

Site of Oedema

Conclusion:

The lymphoedema service in a SPC setting provides valuable input to patients who develop oedema as a result of their condition. The majority of patients were seen within six months of developing oedema.

Further research is required to evaluate the service over a longer period of time and explore the types of interventions provided to this population.

References:

Lymphoedema Dept., St Francis Hospice Dublin

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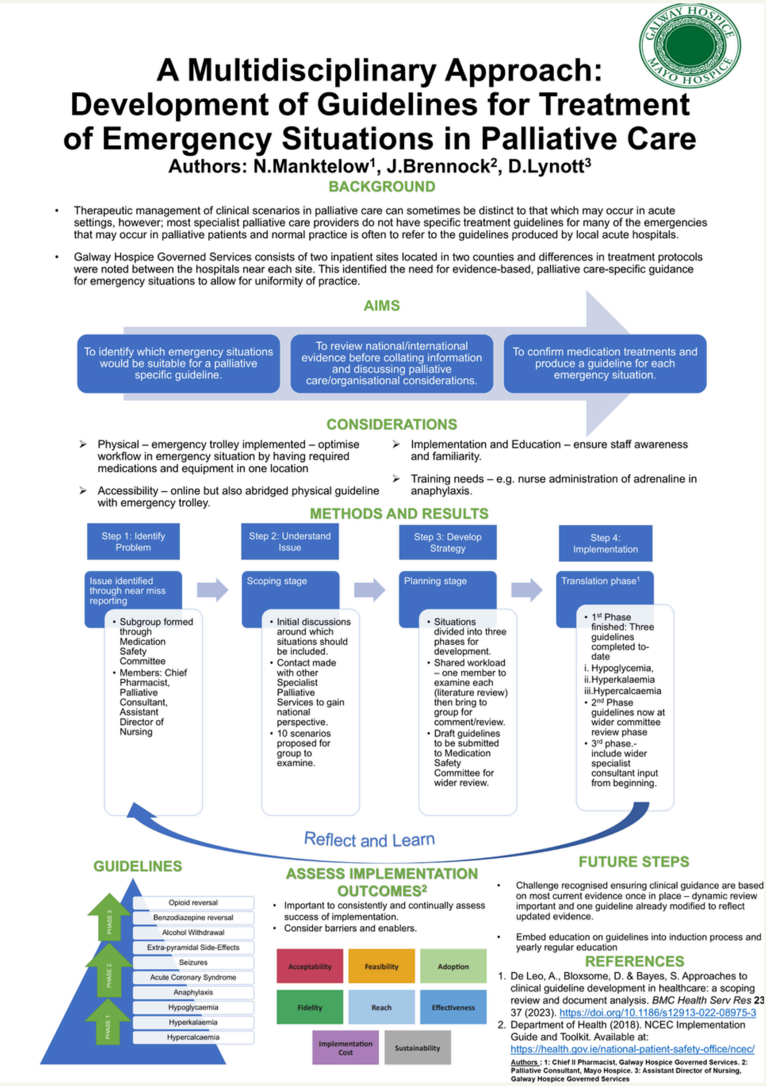
St. Francis Hospice

Title: A service evaluation on the Lymphoedema Service in a Specialist Palliative Care Setting

Authors: Garty

Research



A Multidisciplinary Approach: Development of Guidelines for Treatment of Emergency Situations in Palliative Care

Authors: N.Manktelow[1], J.Brennock[2], D.Lynott[3]

BACKGROUND

- Therapeutic management of clinical scenarios in palliative care can sometimes be distinct to that which may occur in acute settings, however; most specialist palliative care providers do not have specific treatment guidelines for many of the emergencies that may occur in palliative patients and normal practice is often to refer to the guidelines produced by local acute hospitals.
- Galway Hospice Governed Services consists of two inpatient sites located in two counties and differences in treatment protocols were noted between the hospitals near each site. This identified the need for evidence-based, palliative care-specific guidance for emergency situations to allow for uniformity of practice.

AIMS

- To identify which emergency situations would be suitable for a palliative specific guideline.
- To review national/international evidence before collating information and discussing palliative care/organisational considerations.
- To confirm medication treatments and produce a guideline for each emergency situation.

CONSIDERATIONS

- Physical – emergency trolley implemented – optimise workflow in emergency situation by having required medications and equipment in one location
- Accessibility – online but also abridged physical guideline with emergency trolley.
- Implementation and Education – ensure staff awareness and familiarity.
- Training needs – e.g. nurse administration of adrenaline in anaphylaxis.

METHODS AND RESULTS

Step 1: Identify Problem

Issue identified through near miss reporting

- Subgroup formed through Medication Safety Committee
- Members: Chief Pharmacist, Palliative Consultant, Assistant Director of Nursing

Step 2: Understand Issue

Scoping stage

- Initial discussions around which situations should be included.
- Contact made with other Specialist Palliative Services to gain national perspective.
- 10 scenarios proposed for group to examine.

Step 3: Develop Strategy

Planning stage

- Situations divided into three phases for development.
- Shared workload – one member to examine each (literature review) then bring to group for comment/review.
- Draft guidelines to be submitted to Medication Safety Committee for wider review.

Step 4: Implementation

Translation phase[1]

- 1st Phase finished: Three guidelines completed to-date
  i. Hypoglycemia,
  ii. Hyperkalaemia
  iii. Hypercalcaemia
- 2nd Phase guidelines now at wider committee review phase
- 3rd phase.- include wider specialist consultant input from beginning.

Reflect and Learn

GUIDELINES

PHASE 3
- Opioid reversal
- Benzodiazepine reversal
- Alcohol Withdrawal

PHASE 2
- Extra-pyramidal Side-Effects
- Seizures
- Acute Coronary Syndrome
- Anaphylaxis

PHASE 1
- Hypoglycaemia
- Hyperkalaemia
- Hypercalcaemia

ASSESS IMPLEMENTATION OUTCOMES[2]

- Important to consistently and continually assess success of implementation.
- Consider barriers and enablers.

Acceptability	Feasibility	Adoption
Fidelity	Reach	Effectiveness
Implementation Cost	Sustainability	

FUTURE STEPS

- Challenge recognised ensuring clinical guidance are based on most current evidence once in place – dynamic review important and one guideline already modified to reflect updated evidence.
- Embed education on guidelines into induction process and yearly regular education

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Authors : 1: Chief II Pharmacist, Galway Hospice Governed Services. 2: Palliative Consultant, Mayo Hospice. 3: Assistant Director of Nursing, Galway Hospice Governed Services

Title: A Multidisciplinary Approach: Development of Guidelines for Treatment of Emergency Situations in Palliative Care

Authors: Manktelow, Brennock, Lynott

Research

Antibiotic Decisions at the End-of-Life: A Cross-Specialty Approach

Authors: Dr Adrian Chapman Yan[1], Dr Karen Fitzmaurice[2, 3], Dr Karie Dennehy[1],
Dr Mary Jane O'Leary[1], Prof Corinna Sadlier[2], Dr Kieran O'Connor[3], Dr Richard Bambury[2]

1. Marymount University Hospital and Hospice, Cork
2. Cork University Hospital, Cork
3. Mercy University Hospital, Cork

Background:

In the Irish context, we have not identified any reports on antimicrobial prescribing at the end-of-life and there are no national recommendations. There are unique considerations in the end-of-life; during this time, the primary goals are managing symptoms, improving comfort and optimising quality of life.

- **Infection Susceptibility**: In the end-of-life, patients are often more susceptible to infection due to multimorbidity, functional debility and complex disease processes which may compromise host resistance.
- **Overlapping Symptoms and Signs**: Antimicrobials are sometimes prescribed empirically based on symptoms and signs which overlap between infection and non-infectious aetiologies (including those seen when dying).
- **Questionable efficacy in symptom control**: Evidence for antibiotic use as effective symptom control is weak (Rosenberg et al. 2013) and this must be balanced against the significant risk of harm.
- **Aging population**: The prevalence of dementia in Ireland is increasing drastically (Pierse et al. 2019); patients with dementia who are nearing the end-of-life often receive aggressive treatments which might be of uncertain benefit
- **Widespread use**: "Close to 90% of hospitalized patients with advanced cancer receive antimicrobials during the week prior to death" (Thompson et al. 2012)

The majority of current literature in this area was carried out by single specialty groups. We felt we could yield a better depth of understanding with a cross-specialty approach to the study design. The research group included Palliative Care, Infectious Diseases, Geriatric Medicine and Oncology

Aims and Objectives:

To elucidate the attitudes and perspectives of prescribers in our local settings to inform strategies which may optimise good practice here.

Methods:

We devised a survey with a combination of 5-point Likert scale questions and open text boxes to enable participants to express further opinions.

UCC Clinical Research Ethics Committee Approval → Distribution of the Survey to doctors of ALL specialties across **Cork University Hospital** (Model 4) and **Mercy University Hospital** (Model 3) → Re-invitation 4 months later → **Data analysis: Mixed qualitative/quantitative data analysis** → Likert data: Compared means of the answers. Split the answers by demographics to identify differences/patterns; Open text assessed for common themes → Findings and Future Direction

Findings and Results:

136 Responses (600 invitations sent)

68% Medical Specialties

26 Specialties represented

Confidence in diagnosing dying by grade

Common theme: Discussions around antibiotics in the End-of-life are "poorly done" and "not done enough"

"I always discuss antimicrobials including risks and benefits when discussing end of life goals of care"
37% strongly agree, Mean 2.9

"After a diagnosis of dying, there should always be a frank and open discussion with patients about the use of antibiotics in this period"
73% strongly agree, Mean 3.86

Clinicians tend to place more importance on aspects of care related to their specialty

"When deciding about the use of antibiotics in the end-of-life phase, how important are the following factors to you?"
(Not important: 1 to Extremely important: 5)

01. **Patient is a nursing home resident**
Geriatric medicine: 3.16
Average overall: 2.88

02. **Patient's primary diagnosis is cancer**
Oncology: 4.00
Average overall: 2.72

03. **Concern about antimicrobial resistance**
Infectious Diseases/Microbiology: 3.25
Average overall: 2.61

04. **Concern about adverse effects incl. allergy**
Infectious Diseases/Microbiology: 4.5
Average overall: 3.49

"I think education especially from palliative care teams and discussions from them would be useful surrounding this topic. It's a difficult subject and fear of litigation or of not giving your patient "enough of a chance " is always at the forefront." - SHO

Common themes and study highlights:

01. **Diagnosis of dying can be challenging**
02. **Discussion around antibiotics in the End-of-Life Goals conversation are "poorly done" and "not done enough"**
03. **The goals and limits of antibiotic therapy should be defined and agreed**
04. **Doctors from all grades and multiple specialties mentioned the need for education and teaching**
05. **Many responses mentioned the need for a tool or a guideline**
06. **Harms associated with antimicrobials may be less considered than the potential benefits**
07. **Fear of litigation or of "not doing everything" is a significant concern**

Conclusion and Future Directions:

Need for multidisciplinary approach

- We observed that specialties in our study ranked questions relevant to their discipline as more important factors compared to the average. This may be intuitive, given we are more likely to pay more attention to things we understand better
- However, it demonstrates the benefit of a collaborative approach – as patients often present with multimorbidity, particularly at the End-of-Life. A collaborative cross-specialty approach allows us to make considerations beyond the scope of our usual practice, ultimately benefitting the patient as decisions become better informed

Further Education and training

- The open text and survey responses demonstrated that antibiotic use in end-of-life care goals discussions is not done enough
- There was a desire for training in this area and we hope to achieve this through simulation sessions and education modules

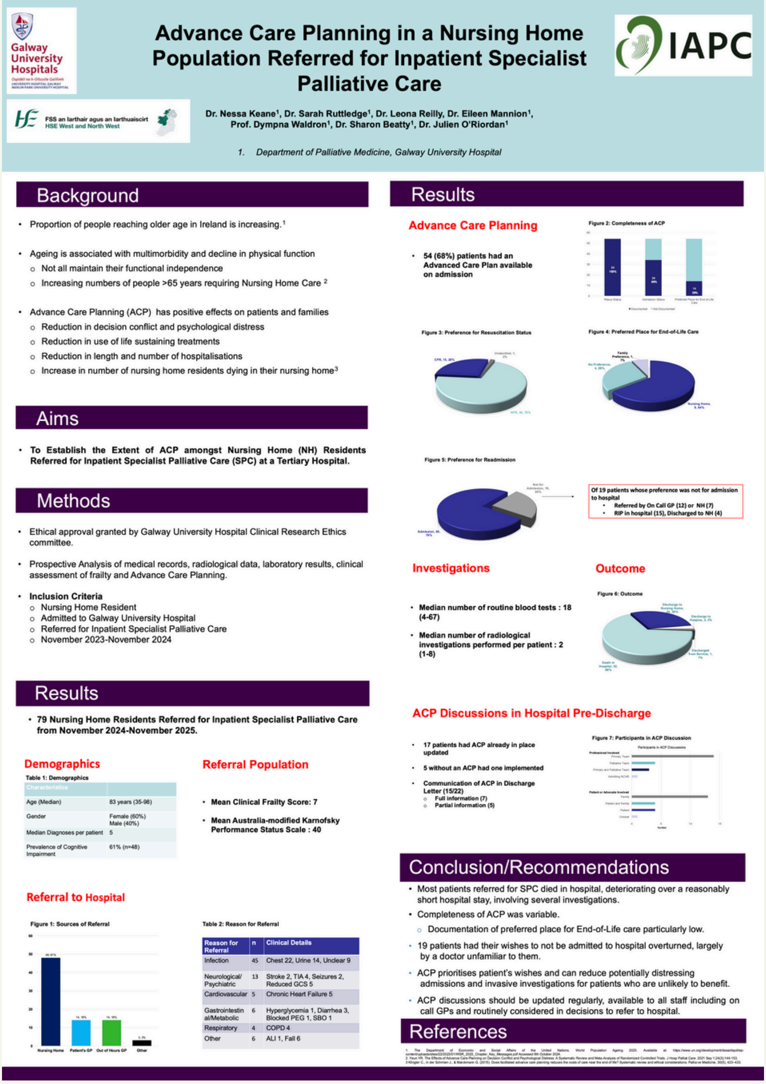
Collaboration

- We are in the early stages of collaborating with organisations such as AMRIC to further develop and disseminate the lessons from our findings

Title: Antibiotic Decisions at the End-of-Life: A Cross-Specialty Approach

Authors: Yan, Dennehy, O'Leary, Fitzmaurice, Sadlier, O'Connor, Bambury, Dahly

Research



Advance Care Planning in a Nursing Home Population Referred for Inpatient Specialist Palliative Care

Dr. Nessa Keane[1], Dr. Sarah Ruttledge[1], Dr. Leona Reilly, Dr. Eileen Mannion[1], Prof. Dympna Waldron[1], Dr. Sharon Beatty[1], Dr. Julien O'Riordan[1]

1. *Department of Palliative Medicine, Galway University Hospital*

Background

- Proportion of people reaching older age in Ireland is increasing.[1]
- Ageing is associated with multimorbidity and decline in physical function
  - Not all maintain their functional independence
  - Increasing numbers of people >65 years requiring Nursing Home Care [2]
- Advance Care Planning (ACP) has positive effects on patients and families
  - Reduction in decision conflict and psychological distress
  - Reduction in use of life sustaining treatments
  - Reduction in length and number of hospitalisations
  - Increase in number of nursing home residents dying in their nursing home[3]

Aims

- **To Establish the Extent of ACP amongst Nursing Home (NH) Residents Referred for Inpatient Specialist Palliative Care (SPC) at a Tertiary Hospital.**

Methods

- Ethical approval granted by Galway University Hospital Clinical Research Ethics committee.
- Prospective Analysis of medical records, radiological data, laboratory results, clinical assessment of frailty and Advance Care Planning.
- **Inclusion Criteria**
  - Nursing Home Resident
  - Admitted to Galway University Hospital
  - Referred for Inpatient Specialist Palliative Care
  - November 2023-November 2024

Results

- **79 Nursing Home Residents Referred for Inpatient Specialist Palliative Care from November 2024-November 2025.**

Demographics

Table 1: Demographics

Characteristics	
Age (Median)	83 years (35-98)
Gender	Female (60%) Male (40%)
Median Diagnoses per patient	5
Prevalence of Cognitive Impairment	61% (n=48)

Referral Population

- **Mean Clinical Frailty Score: 7**
- **Mean Australia-modified Karnofsky Performance Status Scale : 40**

Referral to Hospital

Figure 1: Sources of Referral

Table 2: Reason for Referral

Reason for Referral	n	Clinical Details
Infection	45	Chest 22, Urine 14, Unclear 9
Neurological/ Psychiatric	13	Stroke 2, TIA 4, Seizures 2, Reduced GCS 5
Cardiovascular	5	Chronic Heart Failure 5
Gastrointestinal/Metabolic	6	Hyperglycemia 1, Diarrhea 3, Blocked PEG 1, SBO 1
Respiratory	4	COPD 4
Other	6	ALI 1, Fall 6

Results

Advance Care Planning

- **54 (68%) patients had an Advanced Care Plan available on admission**

Figure 2: Completeness of ACP

Figure 3: Preference for Resuscitation Status

Figure 4: Preferred Place for End-of-Life Care

Figure 5: Preference for Readmission

Of 19 patients whose preference was not for admission to hospital
- Referred by On Call GP (12) or NH (7)
- RIP in hospital (15), Discharged to NH (4)

Investigations

- **Median number of routine blood tests : 18 (4-67)**
- **Median number of radiological investigations performed per patient : 2 (1-8)**

Outcome

Figure 6: Outcome

ACP Discussions in Hospital Pre-Discharge

- **17 patients had ACP already in place updated**
- **5 without an ACP had one implemented**
- **Communication of ACP in Discharge Letter (15/22)**
  - **Full information (7)**
  - **Partial information (5)**

Figure 7: Participants in ACP Discussion

Conclusion/Recommendations

- Most patients referred for SPC died in hospital, deteriorating over a reasonably short hospital stay, involving several investigations.
- Completeness of ACP was variable.
  - Documentation of preferred place for End-of-Life care particularly low.
- 19 patients had their wishes to not be admitted to hospital overturned, largely by a doctor unfamiliar to them.
- ACP prioritises patient's wishes and can reduce potentially distressing admissions and invasive investigations for patients who are unlikely to benefit.
- ACP discussions should be updated regularly, available to all staff including on call GPs and routinely considered in decisions to refer to hospital.

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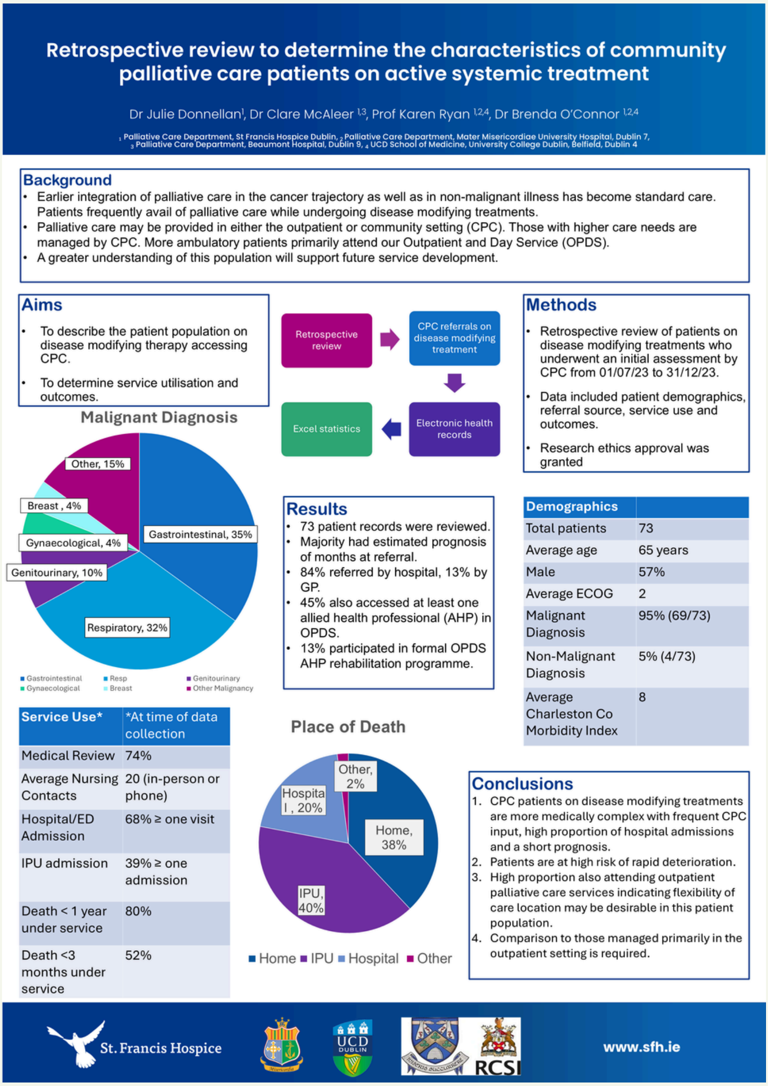
3 Klingler C., in der Schmien J., & Marckmann G. (2015). Does facilitated advance care planning reduces the costs of care near the end of life? Systematic review and ethical considerations. Palliative Medicine, 30(5), 423-433.

Title: Advance Care Planning in a Nursing Home Population referred for Inpatient Specialist Palliative Care

Authors: Keane, Ruttledge, Mannion, Reilly, Waldron, Beatty, O'Riordan

Research



Retrospective review to determine the characteristics of community palliative care patients on active systemic treatment

Dr Julie Donnellan[1], Dr Clare McAleer [1,3], Prof Karen Ryan [1,2,4], Dr Brenda O'Connor [1,2,4]

[1] Palliative Care Department, St Francis Hospice Dublin, [2] Palliative Care Department, Mater Misericordiae University Hospital, Dublin 7, [3] Palliative Care Department, Beaumont Hospital, Dublin 9, [4] UCD School of Medicine, University College Dublin, Belfield, Dublin 4

Background

- Earlier integration of palliative care in the cancer trajectory as well as in non-malignant illness has become standard care. Patients frequently avail of palliative care while undergoing disease modifying treatments.
- Palliative care may be provided in either the outpatient or community setting (CPC). Those with higher care needs are managed by CPC. More ambulatory patients primarily attend our Outpatient and Day Service (OPDS).
- A greater understanding of this population will support future service development.

Aims

- To describe the patient population on disease modifying therapy accessing CPC.
- To determine service utilisation and outcomes.

Retrospective review → CPC referrals on disease modifying treatment → Electronic health records → Excel statistics

Methods

- Retrospective review of patients on disease modifying treatments who underwent an initial assessment by CPC from 01/07/23 to 31/12/23.
- Data included patient demographics, referral source, service use and outcomes.
- Research ethics approval was granted

Malignant Diagnosis

Gastrointestinal, 35%
Respiratory, 32%
Genitourinary, 10%
Gynaecological, 4%
Breast , 4%
Other, 15%

■ Gastrointestinal ■ Resp ■ Genitourinary
■ Gynaecological ■ Breast ■ Other Malignancy

Results

- 73 patient records were reviewed.
- Majority had estimated prognosis of months at referral.
- 84% referred by hospital, 13% by GP.
- 45% also accessed at least one allied health professional (AHP) in OPDS.
- 13% participated in formal OPDS AHP rehabilitation programme.

Demographics	
Total patients	73
Average age	65 years
Male	57%
Average ECOG	2
Malignant Diagnosis	95% (69/73)
Non-Malignant Diagnosis	5% (4/73)
Average Charleston Co Morbidity Index	8

Service Use*	*At time of data collection
Medical Review	74%
Average Nursing Contacts	20 (in-person or phone)
Hospital/ED Admission	68% ≥ one visit
IPU admission	39% ≥ one admission
Death < 1 year under service	80%
Death <3 months under service	52%

Place of Death

Home, 38%
IPU, 40%
Hospital , 20%
Other, 2%

■ Home ■ IPU ■ Hospital ■ Other

Conclusions

1. CPC patients on disease modifying treatments are more medically complex with frequent CPC input, high proportion of hospital admissions and a short prognosis.
2. Patients are at high risk of rapid deterioration.
3. High proportion also attending outpatient palliative care services indicating flexibility of care location may be desirable in this patient population.
4. Comparison to those managed primarily in the outpatient setting is required.

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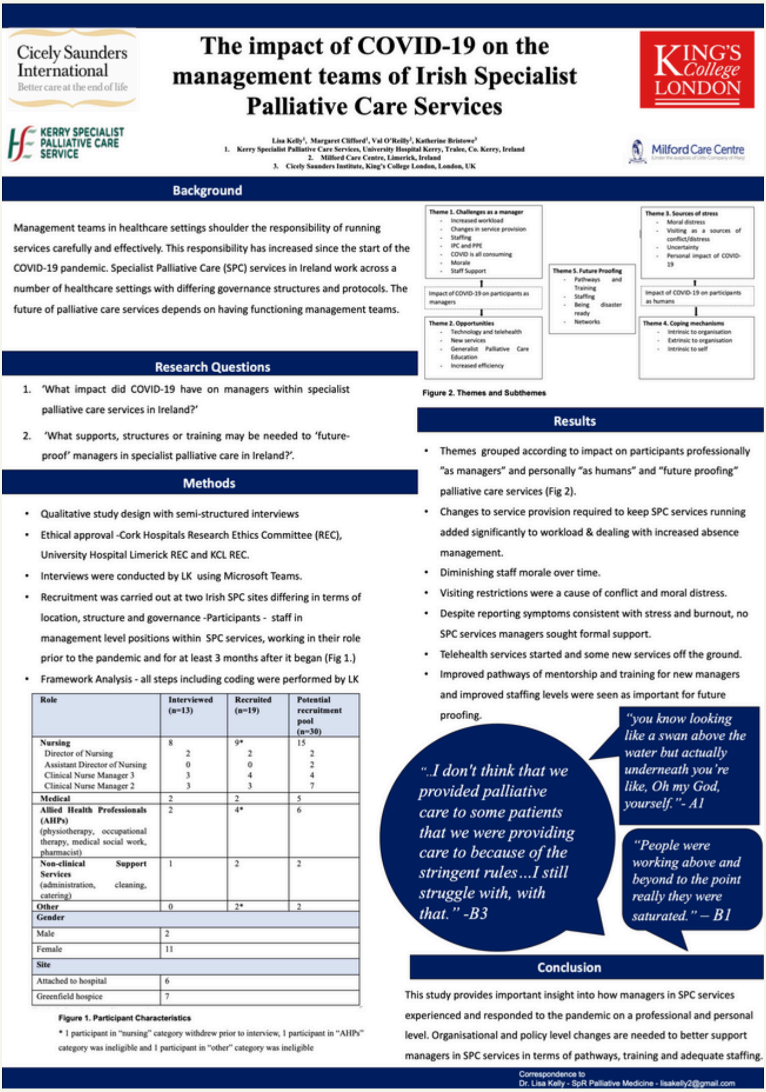
Title: Retrospective review to determine the characteristics of community palliative care patients on active systemic treatment

Authors: Donnellan, McAleer, Ryan, O'Connor

Research



The impact of COVID-19 on the management teams of Irish Specialist Palliative Care Services

Lisa Kelly[1], Margaret Clifford[1], Val O'Reilly[2], Katherine Bristowe[3]
1. Kerry Specialist Palliative Care Services, University Hospital Kerry, Tralee, Co. Kerry, Ireland
2. Milford Care Centre, Limerick, Ireland
3. Cicely Saunders Institute, King's College London, London, UK

Background

Management teams in healthcare settings shoulder the responsibility of running services carefully and effectively. This responsibility has increased since the start of the COVID-19 pandemic. Specialist Palliative Care (SPC) services in Ireland work across a number of healthcare settings with differing governance structures and protocols. The future of palliative care services depends on having functioning management teams.

Research Questions

1. 'What impact did COVID-19 have on managers within specialist palliative care services in Ireland?'
2. 'What supports, structures or training may be needed to 'future-proof' managers in specialist palliative care in Ireland?'.

Methods

- Qualitative study design with semi-structured interviews
- Ethical approval -Cork Hospitals Research Ethics Committee (REC), University Hospital Limerick REC and KCL REC.
- Interviews were conducted by LK using Microsoft Teams.
- Recruitment was carried out at two Irish SPC sites differing in terms of location, structure and governance -Participants - staff in management level positions within SPC services, working in their role prior to the pandemic and for at least 3 months after it began (Fig 1.)
- Framework Analysis - all steps including coding were performed by LK

Role	Interviewed (n=13)	Recruited (n=19)	Potential recruitment pool (n=30)
Nursing	8	9*	15
Director of Nursing	2	2	2
Assistant Director of Nursing	0	0	2
Clinical Nurse Manager 3	3	4	4
Clinical Nurse Manager 2	3	3	7
Medical	2	2	5
Allied Health Professionals (AHPs) (physiotherapy, occupational therapy, medical social work, pharmacist)	2	4*	6
Non-clinical Support Services (administration, cleaning, catering)	1	2	2
Other	0	2*	2
Gender			
Male	2		
Female	11		
Site			
Attached to hospital	6		
Greenfield hospice	7		

Figure 1. Participant Characteristics

* 1 participant in "nursing" category withdrew prior to interview, 1 participant in "AHPs" category was ineligible and 1 participant in "other" category was ineligible

Theme 1. Challenges as a manager
- Increased workload
- Changes in service provision
- Staffing
- IPC and PPE
- COVID is all consuming
- Morale
- Staff Support

Impact of COVID-19 on participants as managers

Theme 2. Opportunities
- Technology and telehealth
- New services
- Generalist Palliative Care Education
- Increased efficiency

Theme 5. Future Proofing
- Pathways and Training
- Staffing
- Being disaster ready
- Networks

Theme 3. Sources of stress
- Moral distress
- Visiting as a sources of conflict/distress
- Uncertainty
- Personal impact of COVID-19

Impact of COVID-19 on participants as humans

Theme 4. Coping mechanisms
- Intrinsic to organisation
- Extrinsic to organisation
- Intrinsic to self

Figure 2. Themes and Subthemes

Results

- Themes grouped according to impact on participants professionally "as managers" and personally "as humans" and "future proofing" palliative care services (Fig 2).
- Changes to service provision required to keep SPC services running added significantly to workload & dealing with increased absence management.
- Diminishing staff morale over time.
- Visiting restrictions were a cause of conflict and moral distress.
- Despite reporting symptoms consistent with stress and burnout, no SPC services managers sought formal support.
- Telehealth services started and some new services off the ground.
- Improved pathways of mentorship and training for new managers and improved staffing levels were seen as important for future proofing.

"..I don't think that we provided palliative care to some patients that we were providing care to because of the stringent rules…I still struggle with, with that." -B3

"you know looking like a swan above the water but actually underneath you're like, Oh my God, yourself."- A1

"People were working above and beyond to the point really they were saturated." – B1

Conclusion

This study provides important insight into how managers in SPC services experienced and responded to the pandemic on a professional and personal level. Organisational and policy level changes are needed to better support managers in SPC services in terms of pathways, training and adequate staffing.

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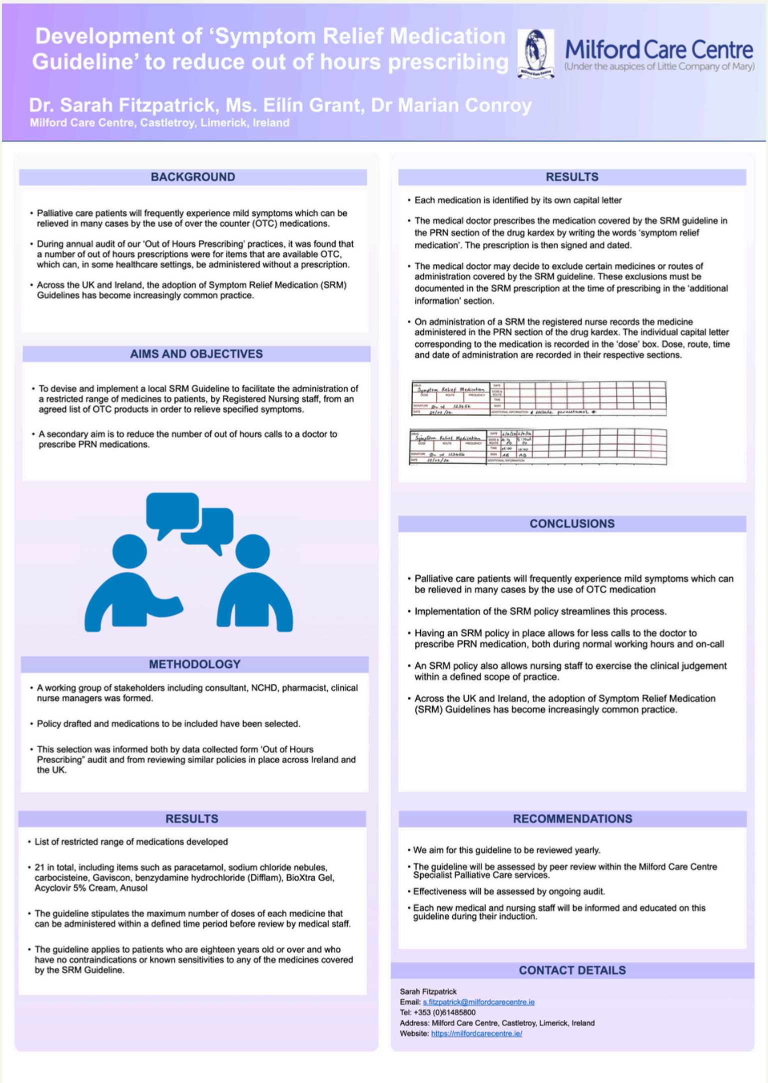
Title: The impact of COVID-19 on the management teams of Irish Specialist Palliative Care Services

Authors: Kelly, Clifford, O'Reilly, Bristowe

Research



Development of 'Symptom Relief Medication Guideline' to reduce out of hours prescribing

Milford Care Centre
(Under the auspices of Little Company of Mary)

Dr. Sarah Fitzpatrick, Ms. Eilín Grant, Dr Marian Conroy
Milford Care Centre, Castletroy, Limerick, Ireland

BACKGROUND

- Palliative care patients will frequently experience mild symptoms which can be relieved in many cases by the use of over the counter (OTC) medications.
- During annual audit of our 'Out of Hours Prescribing' practices, it was found that a number of out of hours prescriptions were for items that are available OTC, which can, in some healthcare settings, be administered without a prescription.
- Across the UK and Ireland, the adoption of Symptom Relief Medication (SRM) Guidelines has become increasingly common practice.

AIMS AND OBJECTIVES

- To devise and implement a local SRM Guideline to facilitate the administration of a restricted range of medicines to patients, by Registered Nursing staff, from an agreed list of OTC products in order to relieve specified symptoms.
- A secondary aim is to reduce the number of out of hours calls to a doctor to prescribe PRN medications.

METHODOLOGY

- A working group of stakeholders including consultant, NCHD, pharmacist, clinical nurse managers was formed.
- Policy drafted and medications to be included have been selected.
- This selection was informed both by data collected form 'Out of Hours Prescribing" audit and from reviewing similar policies in place across Ireland and the UK.

RESULTS

- List of restricted range of medications developed
- 21 in total, including items such as paracetamol, sodium chloride nebules, carbocisteine, Gaviscon, benzydamine hydrochloride (Difflam), BioXtra Gel, Acyclovir 5% Cream, Anusol
- The guideline stipulates the maximum number of doses of each medicine that can be administered within a defined time period before review by medical staff.
- The guideline applies to patients who are eighteen years old or over and who have no contraindications or known sensitivities to any of the medicines covered by the SRM Guideline.

RESULTS

- Each medication is identified by its own capital letter
- The medical doctor prescribes the medication covered by the SRM guideline in the PRN section of the drug kardex by writing the words 'symptom relief medication'. The prescription is then signed and dated.
- The medical doctor may decide to exclude certain medicines or routes of administration covered by the SRM guideline. These exclusions must be documented in the SRM prescription at the time of prescribing in the 'additional information' section.
- On administration of a SRM the registered nurse records the medicine administered in the PRN section of the drug kardex. The individual capital letter corresponding to the medication is recorded in the 'dose' box. Dose, route, time and date of administration are recorded in their respective sections.

CONCLUSIONS

- Palliative care patients will frequently experience mild symptoms which can be relieved in many cases by the use of OTC medication
- Implementation of the SRM policy streamlines this process.
- Having an SRM policy in place allows for less calls to the doctor to prescribe PRN medication, both during normal working hours and on-call
- An SRM policy also allows nursing staff to exercise the clinical judgement within a defined scope of practice.
- Across the UK and Ireland, the adoption of Symptom Relief Medication (SRM) Guidelines has become increasingly common practice.

RECOMMENDATIONS

- We aim for this guideline to be reviewed yearly.
- The guideline will be assessed by peer review within the Milford Care Centre Specialist Palliative Care services.
- Effectiveness will be assessed by ongoing audit.
- Each new medical and nursing staff will be informed and educated on this guideline during their induction.

CONTACT DETAILS

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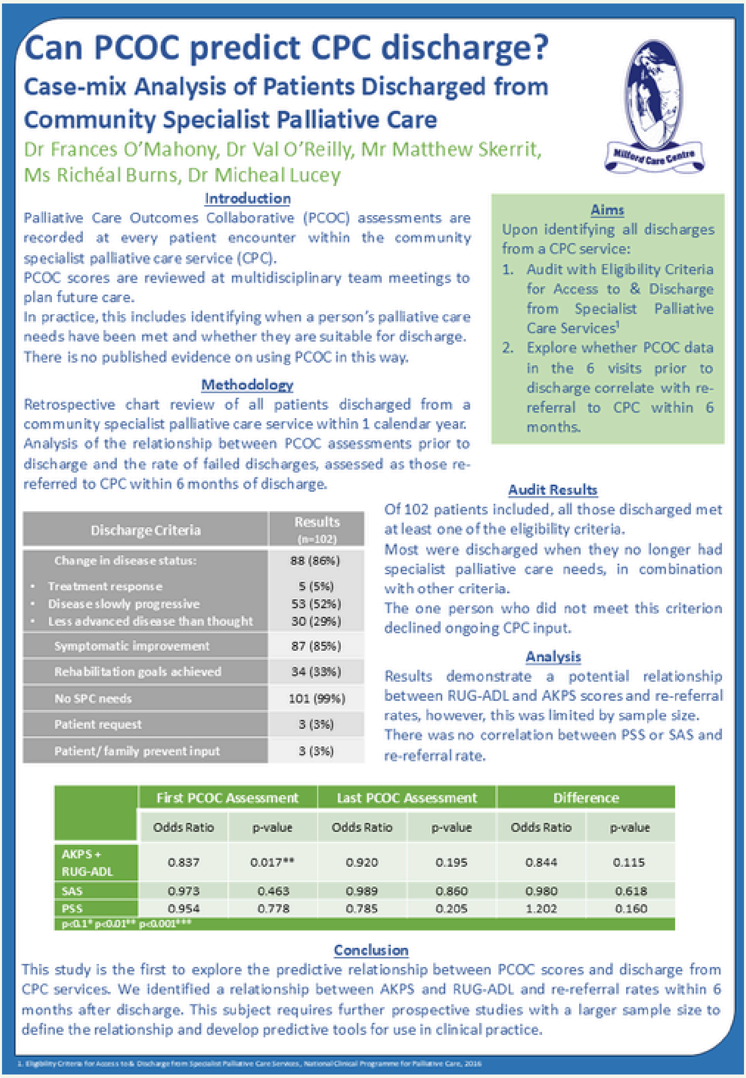
Title: Implementation of 'Symptom Relief Medication Guideline' to reduce out of hours prescribing

Authors: Fitzpatrick, Grant, Conroy

Research



Can PCOC predict CPC discharge?

Case-mix Analysis of Patients Discharged from Community Specialist Palliative Care

Dr Frances O'Mahony, Dr Val O'Reilly, Mr Matthew Skerrit, Ms Richéal Burns, Dr Micheal Lucey

Milford Care Centre

Introduction

Palliative Care Outcomes Collaborative (PCOC) assessments are recorded at every patient encounter within the community specialist palliative care service (CPC).

PCOC scores are reviewed at multidisciplinary team meetings to plan future care.

In practice, this includes identifying when a person's palliative care needs have been met and whether they are suitable for discharge.

There is no published evidence on using PCOC in this way.

Methodology

Retrospective chart review of all patients discharged from a community specialist palliative care service within 1 calendar year.

Analysis of the relationship between PCOC assessments prior to discharge and the rate of failed discharges, assessed as those re-referred to CPC within 6 months of discharge.

Aims

Upon identifying all discharges from a CPC service:

1. Audit with Eligibility Criteria for Access to & Discharge from Specialist Palliative Care Services[1]
2. Explore whether PCOC data in the 6 visits prior to discharge correlate with re-referral to CPC within 6 months.

Discharge Criteria	Results (n=102)
Change in disease status:	88 (86%)
• Treatment response	5 (5%)
• Disease slowly progressive	53 (52%)
• Less advanced disease than thought	30 (29%)
Symptomatic improvement	87 (85%)
Rehabilitation goals achieved	34 (33%)
No SPC needs	101 (99%)
Patient request	3 (3%)
Patient/ family prevent input	3 (3%)

Audit Results

Of 102 patients included, all those discharged met at least one of the eligibility criteria.

Most were discharged when they no longer had specialist palliative care needs, in combination with other criteria.

The one person who did not meet this criterion declined ongoing CPC input.

Analysis

Results demonstrate a potential relationship between RUG-ADL and AKPS scores and re-referral rates, however, this was limited by sample size.

There was no correlation between PSS or SAS and re-referral rate.

	First PCOC Assessment		Last PCOC Assessment		Difference	
	Odds Ratio	p-value	Odds Ratio	p-value	Odds Ratio	p-value
AKPS + RUG-ADL	0.837	0.017**	0.920	0.195	0.844	0.115
SAS	0.973	0.463	0.989	0.860	0.980	0.618
PSS	0.954	0.778	0.785	0.205	1.202	0.160

$p<0.1^{*}$ $p<0.01^{**}$ $p<0.001^{***}$

Conclusion

This study is the first to explore the predictive relationship between PCOC scores and discharge from CPC services. We identified a relationship between AKPS and RUG-ADL and re-referral rates within 6 months after discharge. This subject requires further prospective studies with a larger sample size to define the relationship and develop predictive tools for use in clinical practice.

---

[1] Eligibility Criteria for Access to & Discharge from Specialist Palliative Care Services, National Clinical Programme for Palliative Care, 2016

Title: Can PCOC Predict Re-Referral? Case-mix Analysis of Patients Discharged from Community Specialist Palliative Care

Authors: O'Mahony, O'Reilly, Skerrit, Burns, Lucey

Research

Falls in a single-centre specialist inpatient palliative care unit: a retrospective study

Authors: David Byrne[1], Jide Afolabi[2]

1. Palliative Medicine, Our Lady's Hospice, Harold's Cross
2. Department of Physiotherapy, Our Lady's Hospice, Harold's Cross

Background

- Falls pose a major concern in healthcare environments
- Despite falls strategies, there is limited information available about falls occurring in inpatient palliative care units (IPUs).
- Falls process in OLH:
  - Falls incident report
  - Reported to Falls Officer
  - Falls Data & Trends reviewed annually
  - Risk Officer

Aims

- To report the number and incidence of falls in the IPU in OLH
- To describe characteristics of the falls, the patients & the injuries sustained
- To highlight potential risk factors for falls in the IPU, to inform prevention strategies

Methods

- Analysis of the number of falls reported in a specialist 33-bed academic IPU over a 12 month period.
- Falls data are collected, routinely collated and recorded on a falls database. For each fall, and a narrative description of the fall were recorded by the reporting healthcare worker.

- Outcomes:
  - Patient characteristics
    - Age, male/female, malignancy/non-malignancy
  - Fall characteristics
    - Date and time, location, fall category, injury
    - Toileting (Mobilising to bathroom, using commode, in bathroom)

Results

- There were 45 falls involving 34 patients over 12 month period
- Incidence of 3.7 falls per 1,000 bed-days

- Median of 1 fall (range 1-3) per patient
- 31 (91.2%) had a cancer diagnosis, 3 (8.8%) had a non-cancer diagnosis

Who?

What activity / ADL?

What injury?

Where?

When?

Key Messages / Conclusions

- **Falls risk factor 1:** >1/3 falls related to toileting
- **Falls risk factor 2:** Night / early morning
  - Almost half of falls occurring between midnight and 8am with 40% between 06:00-10:00

Contribution

- First retrospective study of falls in an IPU in Ireland describing both patient and fall characteristics
- Results disseminated at OLH Falls week – feedback to ward staff
- Update in OLH Falls policy

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Title: Falls in a single-centre specialist inpatient palliative care unit: a retrospective review

Authors: Byrne, Afolabi

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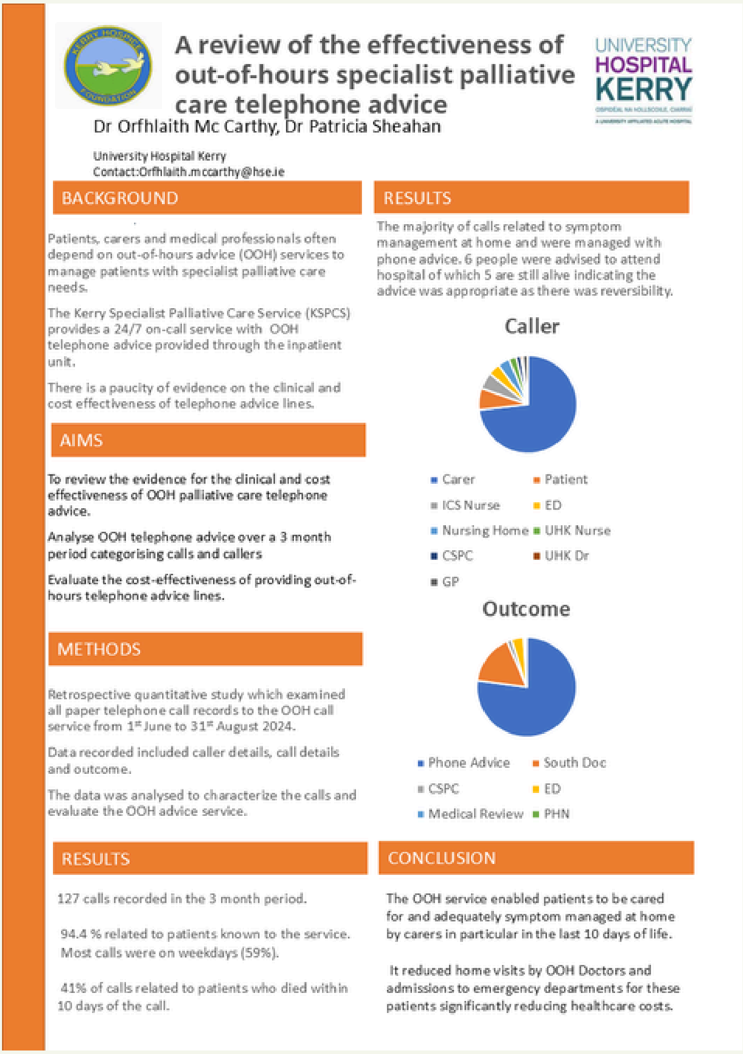


A review of the effectiveness of out-of-hours specialist palliative care telephone advice

Dr Orfhlaith Mc Carthy, Dr Patricia Sheahan

University Hospital Kerry
Contact:Orfhlaith.mccarthy@hse.ie

BACKGROUND

Patients, carers and medical professionals often depend on out-of-hours advice (OOH) services to manage patients with specialist palliative care needs.

The Kerry Specialist Palliative Care Service (KSPCS) provides a 24/7 on-call service with OOH telephone advice provided through the inpatient unit.

There is a paucity of evidence on the clinical and cost effectiveness of telephone advice lines.

AIMS

To review the evidence for the clinical and cost effectiveness of OOH palliative care telephone advice.

Analyse OOH telephone advice over a 3 month period categorising calls and callers

Evaluate the cost-effectiveness of providing out-of-hours telephone advice lines.

METHODS

Retrospective quantitative study which examined all paper telephone call records to the OOH call service from 1st June to 31st August 2024.

Data recorded included caller details, call details and outcome.

The data was analysed to characterize the calls and evaluate the OOH advice service.

RESULTS

127 calls recorded in the 3 month period.

94.4 % related to patients known to the service. Most calls were on weekdays (59%).

41% of calls related to patients who died within 10 days of the call.

RESULTS

The majority of calls related to symptom management at home and were managed with phone advice. 6 people were advised to attend hospital of which 5 are still alive indicating the advice was appropriate as there was reversibility.

CONCLUSION

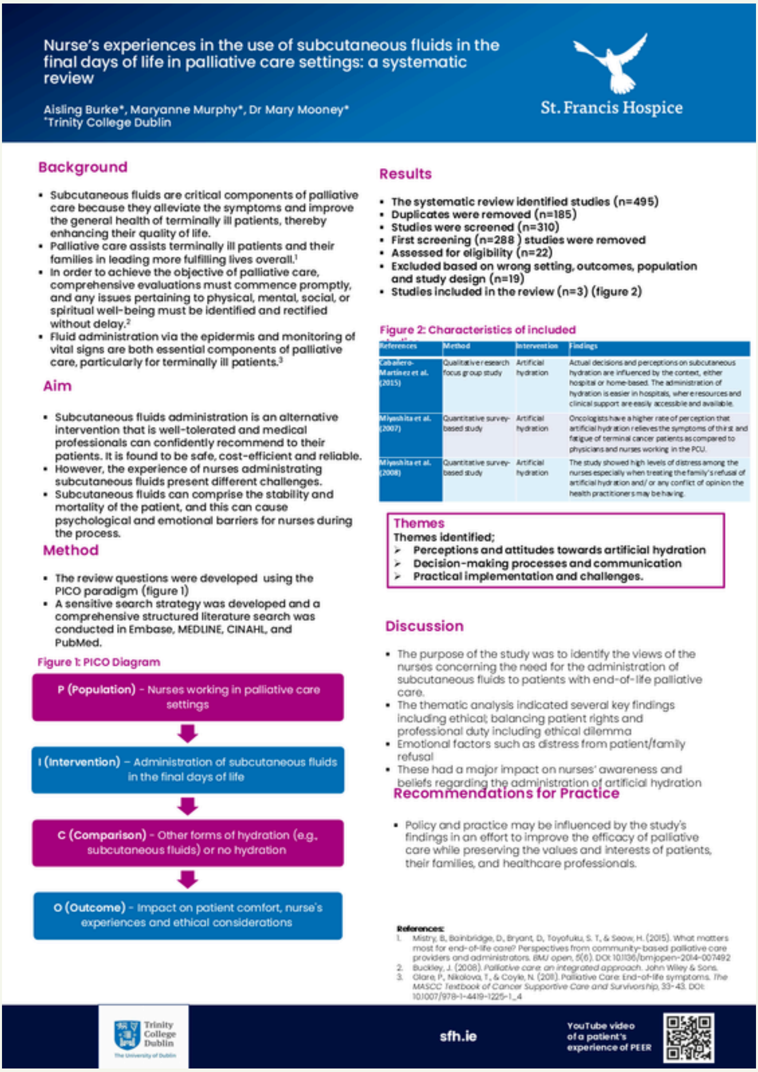
The OOH service enabled patients to be cared for and adequately symptom managed at home by carers in particular in the last 10 days of life.

It reduced home visits by OOH Doctors and admissions to emergency departments for these patients significantly reducing healthcare costs.

Title: A review of the effectiveness of out-of-hours specialist palliative care telephone advice

Authors: McCarthy

Research



Nurse's experiences in the use of subcutaneous fluids in the final days of life in palliative care settings: a systematic review

Aisling Burke*, Maryanne Murphy*, Dr Mary Mooney*
*Trinity College Dublin

St. Francis Hospice

Background

- Subcutaneous fluids are critical components of palliative care because they alleviate the symptoms and improve the general health of terminally ill patients, thereby enhancing their quality of life.
- Palliative care assists terminally ill patients and their families in leading more fulfilling lives overall.[1]
- In order to achieve the objective of palliative care, comprehensive evaluations must commence promptly, and any issues pertaining to physical, mental, social, or spiritual well-being must be identified and rectified without delay.[2]
- Fluid administration via the epidermis and monitoring of vital signs are both essential components of palliative care, particularly for terminally ill patients.[3]

Aim

- Subcutaneous fluids administration is an alternative intervention that is well-tolerated and medical professionals can confidently recommend to their patients. It is found to be safe, cost-efficient and reliable.
- However, the experience of nurses administrating subcutaneous fluids present different challenges.
- Subcutaneous fluids can comprise the stability and mortality of the patient, and this can cause psychological and emotional barriers for nurses during the process.

Method

- The review questions were developed using the PICO paradigm (figure 1)
- A sensitive search strategy was developed and a comprehensive structured literature search was conducted in Embase, MEDLINE, CINAHL, and PubMed.

Figure 1: PICO Diagram

P (Population) - Nurses working in palliative care settings

I (Intervention) – Administration of subcutaneous fluids in the final days of life

C (Comparison) - Other forms of hydration (e.g. subcutaneous fluids) or no hydration

O (Outcome) - Impact on patient comfort, nurse's experiences and ethical considerations

Results

- The systematic review identified studies (n=495)
- Duplicates were removed (n=185)
- Studies were screened (n=310)
- First screening (n=288) studies were removed
- Assessed for eligibility (n=22)
- Excluded based on wrong setting, outcomes, population and study design (n=19)
- Studies included in the review (n=3) (figure 2)

Figure 2: Characteristics of included studies

References	Method	Intervention	Findings
Caballero-Martinez et al. (2015)	Qualitative research focus group study	Artificial hydration	Actual decisions and perceptions on subcutaneous hydration are influenced by the context, either hospital or home-based. The administration of hydration is easier in hospitals, where resources and clinical support are easily accessible and available.
Miyashita et al. (2007)	Quantitative survey-based study	Artificial hydration	Oncologists have a higher rate of perception that artificial hydration relieves the symptoms of thirst and fatigue of terminal cancer patients as compared to physicians and nurses working in the PCU.
Miyashita et al. (2008)	Quantitative survey-based study	Artificial hydration	The study showed high levels of distress among the nurses especially when treating the family's refusal of artificial hydration and/ or any conflict of opinion the health practitioners may be having.

Themes

Themes identified;

- **Perceptions and attitudes towards artificial hydration**
- **Decision-making processes and communication**
- **Practical implementation and challenges.**

Discussion

- The purpose of the study was to identify the views of the nurses concerning the need for the administration of subcutaneous fluids to patients with end-of-life palliative care.
- The thematic analysis indicated several key findings including ethical; balancing patient rights and professional duty including ethical dilemma
- Emotional factors such as distress from patient/family refusal
- These had a major impact on nurses' awareness and beliefs regarding the administration of artificial hydration

Recommendations for Practice

- Policy and practice may be influenced by the study's findings in an effort to improve the efficacy of palliative care while preserving the values and interests of patients, their families, and healthcare professionals.

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Trinity College Dublin
The University of Dublin

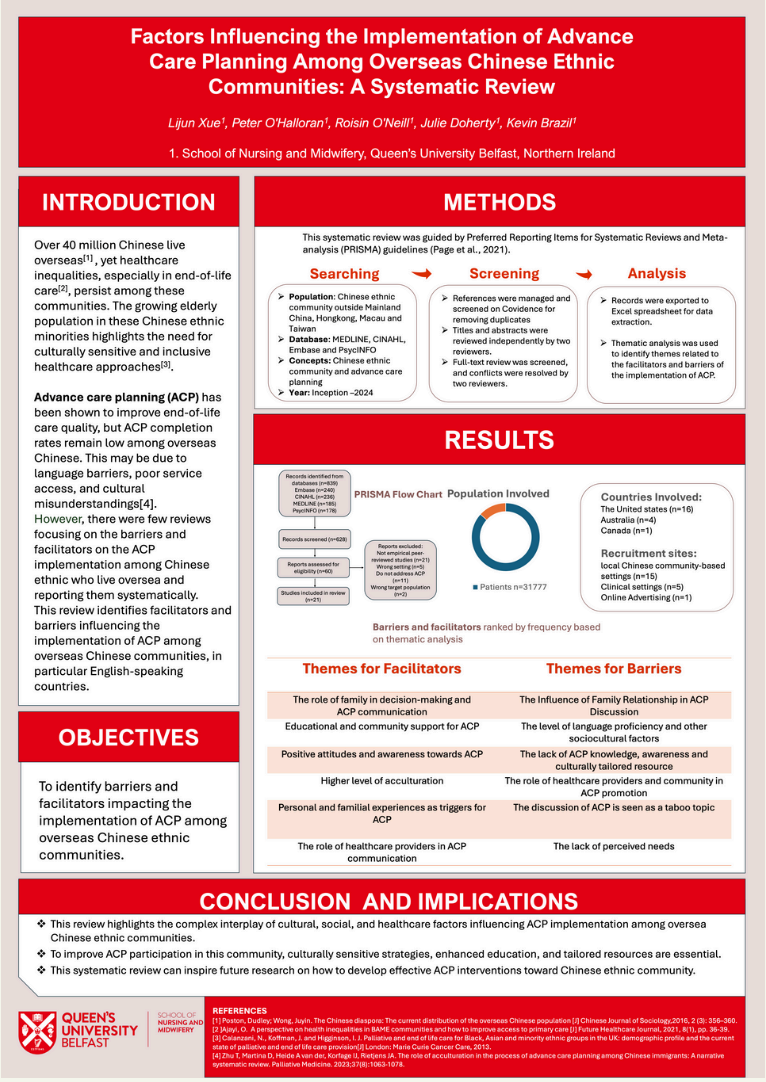
sfh.ie

YouTube video of a patient's experience of PEER

Title: The nurses experience of delivering end of life care in an acute setting in the west of Ireland.

Authors: Kelly

Research



Factors Influencing the Implementation of Advance Care Planning Among Overseas Chinese Ethnic Communities: A Systematic Review

Lijun Xue[1], Peter O'Halloran[1], Roisin O'Neill[1], Julie Doherty[1], Kevin Brazil[1]

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INTRODUCTION

Over 40 million Chinese live overseas[1], yet healthcare inequalities, especially in end-of-life care[2], persist among these communities. The growing elderly population in these Chinese ethnic minorities highlights the need for culturally sensitive and inclusive healthcare approaches[3].

Advance care planning (ACP) has been shown to improve end-of-life care quality, but ACP completion rates remain low among overseas Chinese. This may be due to language barriers, poor service access, and cultural misunderstandings[4]. However, there were few reviews focusing on the barriers and facilitators on the ACP implementation among Chinese ethnic who live oversea and reporting them systematically. This review identifies facilitators and barriers influencing the implementation of ACP among overseas Chinese communities, in particular English-speaking countries.

OBJECTIVES

To identify barriers and facilitators impacting the implementation of ACP among overseas Chinese ethnic communities.

METHODS

This systematic review was guided by Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) guidelines (Page et al., 2021).

Searching

- **Population:** Chinese ethnic community outside Mainland China, Hongkong, Macau and Taiwan
- **Database:** MEDLINE, CINAHL, Embase and PsycINFO
- **Concepts:** Chinese ethnic community and advance care planning
- **Year:** Inception –2024

Screening

- References were managed and screened on Covidence for removing duplicates
- Titles and abstracts were reviewed independently by two reviewers.
- Full-text review was screened, and conflicts were resolved by two reviewers.

Analysis

- Records were exported to Excel spreadsheet for data extraction.
- Thematic analysis was used to identify themes related to the facilitators and barriers of the implementation of ACP.

RESULTS

Records identified from databases (n=839)
Embase (n=240)
CINAHL (n=236)
MEDLINE (n=185)
PsycINFO (n=178)

Records screened (n=628)

Reports assessed for eligibility (n=60)

Reports excluded:
Not empirical peer-reviewed studies (n=21)
Wrong setting (n=5)
Do not address ACP (n=11)
Wrong target population (n=2)

Studies included in review (n=21)

PRISMA Flow Chart

Population Involved

■ Patients n=31777

Countries Involved:
The United states (n=16)
Australia (n=4)
Canada (n=1)

Recruitment sites:
local Chinese community-based settings (n=15)
Clinical settings (n=5)
Online Advertising (n=1)

Barriers and facilitators ranked by frequency based on thematic analysis

Themes for Facilitators	Themes for Barriers
The role of family in decision-making and ACP communication	The Influence of Family Relationship in ACP Discussion
Educational and community support for ACP	The level of language proficiency and other sociocultural factors
Positive attitudes and awareness towards ACP	The lack of ACP knowledge, awareness and culturally tailored resource
Higher level of acculturation	The role of healthcare providers and community in ACP promotion
Personal and familial experiences as triggers for ACP	The discussion of ACP is seen as a taboo topic
The role of healthcare providers in ACP communication	The lack of perceived needs

CONCLUSION AND IMPLICATIONS

❖ This review highlights the complex interplay of cultural, social, and healthcare factors influencing ACP implementation among oversea Chinese ethnic communities.
❖ To improve ACP participation in this community, culturally sensitive strategies, enhanced education, and tailored resources are essential.
❖ This systematic review can inspire future research on how to develop effective ACP interventions toward Chinese ethnic community.

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Title: Factors Influencing Advance Care Planning Implementation Among Overseas Chinese Ethnic Communities: A Systematic Review

Authors: Xue, O'Halloran, O'Neill, Doherty, Brazil

Research

Sláinte Leanaí Éireann
CHI
Children's Health Ireland

CONFRONTING CLONIDINE CONFUSION: A Quality Improvement Initiative to aid Prescribing, Applying and Monitoring of Clonidine Transdermal Patches

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2 Department of Palliative Care, CHI at Crumlin
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4 Department of Palliative Care, CHI at Crumlin
5 Pharmacy Department, CHI at Crumlin
6 Department of Palliative Care, CHI at Crumlin

KEY POINTS:

- The specialist palliative care team, along with the pharmacy department, embarked on a quality improvement initiative to explore how to best aid staff in prescribing, applying and monitoring Clonidine Patches for patients across CHI.
- Standard Operating Procedure (SOP) for the Prescribing and Administration of Clonidine Patches was devised by both the Palliative Care and Pharmacy Departments, along with a Clonidine Transdermal Patch Application Record for staff to accurately record and monitor patch application.

BACKGROUND

The use of transdermal clonidine for the management of dystonia in children with severe neurological impairment, has increased in paediatric practice since early 2021. A number of reoccurring prescribing and administration errors started to emerge.

AIM

The specialist palliative care team, along with the pharmacy department embarked on a collaborative quality improvement initiative to reduce the risk of errors and support both staff and families in prescribing, applying and monitoring Clonidine Patches for paediatric patients.

METHODS

A multidisciplinary project team was formed consisting of:

- the medication safety officer
- pharmacists
- members of the specialist palliative care team.

The multidisciplinary project team identified the factors contributing to the errors including; the use of unlicensed medication, packaging information not in the English language, similarity between adhesive covers and patches and lack of guidance in hospital formulary.

RESULTS

Following the review of errors and the feedback obtained from staff, multiple quality improvement initiatives were developed and implemented by the multidisciplinary project team:

- An alternative product with English language packaging was sourced
- The tertiary hospital formulary was updated
- The development of Standard Operating Procedure (SOP) for the Prescribing and Administration of Clonidine Patches
- The addition of a 'Clonidine Transdermal Patch Application Record'
- A new Patient Information Leaflet was designed
- Education provided to staff
- Liaising with the Primary Care Reimbursement Service (PCRS) to ensure consistency in dispensing of patches

Clonidine patch **(left)** and adhesive cover **(right)**

FUTURE DIRECTION

The use of Clonidine Transdermal patches is a relatively new and emerging practice across CHI, with very little international evidence available to aid in safe prescribing and administration.

- The need for a SOP came from feedback from staff and from errors noted.
- An audit on prescribing and monitoring of transdermal clonidine patches in now underway, to assess if there has been a reduction in prescribing and administration errors since the introduction of the SOP

ACKNOWLEDGEMENTS

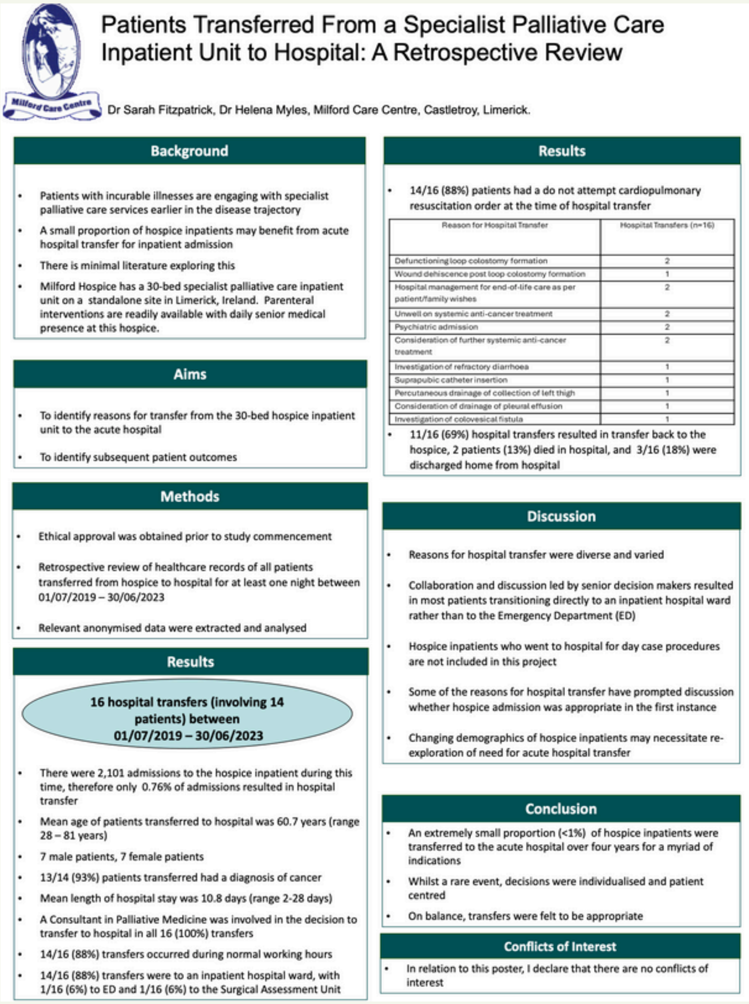
Thanks to colleagues who participated in the development of Clonidine Transdermal Patch Application Record.

In particular, our colleagues in the pharmacy department.

Title: Confronting Clonidine Confusion; An MDT Quality Improvement Initiative to aid prescribing, application and monitoring of Clonidine Transdermal Patches

Authors: Wade, Hurley, Jennings, Moore, Lavelle, Laffan

Research



Patients Transferred From a Specialist Palliative Care Inpatient Unit to Hospital: A Retrospective Review

Dr Sarah Fitzpatrick, Dr Helena Myles, Milford Care Centre, Castletroy, Limerick.

Background

- Patients with incurable illnesses are engaging with specialist palliative care services earlier in the disease trajectory
- A small proportion of hospice inpatients may benefit from acute hospital transfer for inpatient admission
- There is minimal literature exploring this
- Milford Hospice has a 30-bed specialist palliative care inpatient unit on a standalone site in Limerick, Ireland. Parenteral interventions are readily available with daily senior medical presence at this hospice.

Aims

- To identify reasons for transfer from the 30-bed hospice inpatient unit to the acute hospital
- To identify subsequent patient outcomes

Methods

- Ethical approval was obtained prior to study commencement
- Retrospective review of healthcare records of all patients transferred from hospice to hospital for at least one night between 01/07/2019 – 30/06/2023
- Relevant anonymised data were extracted and analysed

Results

16 hospital transfers (involving 14 patients) between 01/07/2019 – 30/06/2023

- There were 2,101 admissions to the hospice inpatient during this time, therefore only 0.76% of admissions resulted in hospital transfer
- Mean age of patients transferred to hospital was 60.7 years (range 28 – 81 years)
- 7 male patients, 7 female patients
- 13/14 (93%) patients transferred had a diagnosis of cancer
- Mean length of hospital stay was 10.8 days (range 2-28 days)
- A Consultant in Palliative Medicine was involved in the decision to transfer to hospital in all 16 (100%) transfers
- 14/16 (88%) transfers occurred during normal working hours
- 14/16 (88%) transfers were to an inpatient hospital ward, with 1/16 (6%) to ED and 1/16 (6%) to the Surgical Assessment Unit

Results

- 14/16 (88%) patients had a do not attempt cardiopulmonary resuscitation order at the time of hospital transfer

Reason for Hospital Transfer	Hospital Transfers (n=16)
Defunctioning loop colostomy formation	2
Wound dehiscence post loop colostomy formation	1
Hospital management for end-of-life care as per patient/family wishes	2
Unwell on systemic anti-cancer treatment	2
Psychiatric admission	2
Consideration of further systemic anti-cancer treatment	2
Investigation of refractory diarrhoea	1
Suprapubic catheter insertion	1
Percutaneous drainage of collection of left thigh	1
Consideration of drainage of pleural effusion	1
Investigation of colovesical fistula	1

- 11/16 (69%) hospital transfers resulted in transfer back to the hospice, 2 patients (13%) died in hospital, and 3/16 (18%) were discharged home from hospital

Discussion

- Reasons for hospital transfer were diverse and varied
- Collaboration and discussion led by senior decision makers resulted in most patients transitioning directly to an inpatient hospital ward rather than to the Emergency Department (ED)
- Hospice inpatients who went to hospital for day case procedures are not included in this project
- Some of the reasons for hospital transfer have prompted discussion whether hospice admission was appropriate in the first instance
- Changing demographics of hospice inpatients may necessitate re-exploration of need for acute hospital transfer

Conclusion

- An extremely small proportion (<1%) of hospice inpatients were transferred to the acute hospital over four years for a myriad of indications
- Whilst a rare event, decisions were individualised and patient centred
- On balance, transfers were felt to be appropriate

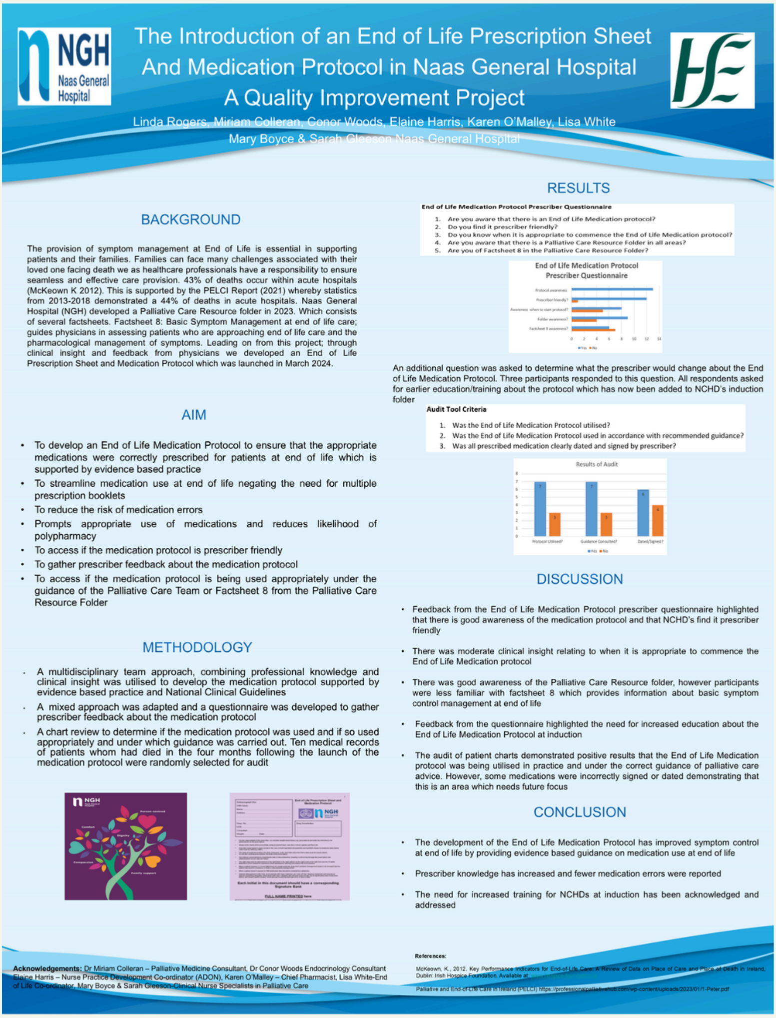
Conflicts of Interest

- In relation to this poster, I declare that there are no conflicts of interest

Title: Patients Transferred from a Specialist Palliative Care Inpatient Unit to Hospital: A Retrospective Review

Authors: Fitzpatrick, Myles

Research



The Introduction of an End of Life Prescription Sheet And Medication Protocol in Naas General Hospital A Quality Improvement Project

Linda Rogers, Miriam Colleran, Conor Woods, Elaine Harris, Karen O'Malley, Lisa White
Mary Boyce & Sarah Gleeson Naas General Hospital

BACKGROUND

The provision of symptom management at End of Life is essential in supporting patients and their families. Families can face many challenges associated with their loved one facing death we as healthcare professionals have a responsibility to ensure seamless and effective care provision. 43% of deaths occur within acute hospitals (McKeown K 2012). This is supported by the PELCI Report (2021) whereby statistics from 2013-2018 demonstrated a 44% of deaths in acute hospitals. Naas General Hospital (NGH) developed a Palliative Care Resource folder in 2023. Which consists of several factsheets. Factsheet 8: Basic Symptom Management at end of life care; guides physicians in assessing patients who are approaching end of life care and the pharmacological management of symptoms. Leading on from this project; through clinical insight and feedback from physicians we developed an End of Life Prescription Sheet and Medication Protocol which was launched in March 2024.

AIM

- To develop an End of Life Medication Protocol to ensure that the appropriate medications were correctly prescribed for patients at end of life which is supported by evidence based practice
- To streamline medication use at end of life negating the need for multiple prescription booklets
- To reduce the risk of medication errors
- Prompts appropriate use of medications and reduces likelihood of polypharmacy
- To access if the medication protocol is prescriber friendly
- To gather prescriber feedback about the medication protocol
- To access if the medication protocol is being used appropriately under the guidance of the Palliative Care Team or Factsheet 8 from the Palliative Care Resource Folder

METHODOLOGY

- A multidisciplinary team approach, combining professional knowledge and clinical insight was utilised to develop the medication protocol supported by evidence based practice and National Clinical Guidelines
- A mixed approach was adapted and a questionnaire was developed to gather prescriber feedback about the medication protocol
- A chart review to determine if the medication protocol was used and if so used appropriately and under which guidance was carried out. Ten medical records of patients whom had died in the four months following the launch of the medication protocol were randomly selected for audit

RESULTS

End of Life Medication Protocol Prescriber Questionnaire

1. Are you aware that there is an End of Life Medication protocol?
2. Do you find it prescriber friendly?
3. Do you know when it is appropriate to commence the End of Life Medication protocol?
4. Are you aware that there is a Palliative Care Resource Folder in all areas?
5. Are you of Factsheet 8 in the Palliative Care Resource Folder?

An additional question was asked to determine what the prescriber would change about the End of Life Medication Protocol. Three participants responded to this question. All respondents asked for earlier education/training about the protocol which has now been added to NCHD's induction folder

Audit Tool Criteria

1. Was the End of Life Medication Protocol utilised?
2. Was the End of Life Medication Protocol used in accordance with recommended guidance?
3. Was all prescribed medication clearly dated and signed by prescriber?

DISCUSSION

- Feedback from the End of Life Medication Protocol prescriber questionnaire highlighted that there is good awareness of the medication protocol and that NCHD's find it prescriber friendly
- There was moderate clinical insight relating to when it is appropriate to commence the End of Life Medication protocol
- There was good awareness of the Palliative Care Resource folder, however participants were less familiar with factsheet 8 which provides information about basic symptom control management at end of life
- Feedback from the questionnaire highlighted the need for increased education about the End of Life Medication Protocol at induction
- The audit of patient charts demonstrated positive results that the End of Life Medication protocol was being utilised in practice and under the correct guidance of palliative care advice. However, some medications were incorrectly signed or dated demonstrating that this is an area which needs future focus

CONCLUSION

- The development of the End of Life Medication Protocol has improved symptom control at end of life by providing evidence based guidance on medication use at end of life
- Prescriber knowledge has increased and fewer medication errors were reported
- The need for increased training for NCHDs at induction has been acknowledged and addressed

Acknowledgements: Dr Miriam Colleran – Palliative Medicine Consultant, Dr Conor Woods Endocrinology Consultant Elaine Harris – Nurse Practice Development Co-ordinator (ADON), Karen O'Malley – Chief Pharmacist, Lisa White-End of Life Co-ordinator, Mary Boyce & Sarah Gleeson-Clinical Nurse Specialists in Palliative Care

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Title: The Development and Implementation of an End of Life Prescription Sheet and Medication Protocol in Naas General Hospital: A Quality Improvement Project

Authors: Gleeson

Research

Chronic disease management in patients at the end of life

Author: Dr. David Byrne[1, 2]

1. Our Lady's Hospice, Harold's Cross, Dublin 6
2. Inchicore Medical, Inchicore, Dublin 8

Introduction

- In 2020, the Health Service Executive (HSE) introduced a Chronic Disease Management (CDM) programme in Primary Care, which delivers 6-monthly structured consultations to patients with specific chronic illnesses:

1. COPD
2. Type 2 Diabetes
3. Heart Failure
4. Stroke / CVA
5. Ischaemic Heart Disease
6. Asthma

- These consultations may be an opportunity to identify patients entering their final year of life, who may benefit from palliative care input.

Aim

- To explore the role of the CDM programme in patients attending primary care who are entering their last year of life.

Methodology

- A retrospective chart review of all deaths in a urban General Practice in an 18-month period from January 2022 to June 2023.
- Data collected: CDM registration status, specialist palliative care input, chronic disease diagnoses, number of medications per patient, interval from last CDM review to death.

Results

15 patients identified	
Demographics	**Age:** Median 74 years (range 33-87) **Sex:** Male 60% (9/15), Female 40% (6/15)
	Multimorbidity (≥2 chronic diseases): 53.3% (8/15) **Polypharmacy (≥5 medications):** Median 13 medications (range 3-22)
CDM Registration status	73% (11/15) registered for the CDM programme

Figure 1: CDM & Palliative input in all deaths (n=15)

Figure 2: CDM Chronic Disease Diagnoses (n=11)

Figure 3: Interval from CDM Review To Death (n=11)

*No patients who died within 6 months of their CDM visit were linked to palliative care

Conclusions and Recommendations

- Almost three quarters (73%) of patients had been registered for the CDM programme within 18 months of death
- Almost half (46%) of registered patients had a CDM consultation in the 6 months before death, none of whom were linked to palliative care
- CDM visits are a potentially useful and timely opportunity to assess end of life care needs
- Further research is required to assess the feasibility and acceptability of incorporating a palliative care review into the CDM assessment

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Title: Chronic Disease Management (CDM) Programme at the end of life

Authors: Byrne

Research

Guideline for Anticipatory Prescribing for Terminal Haemorrhage in Cancer Patients Based on Current Practice in Ireland

Dr G Kennedy, Mr N Manktelow , Dr I Harnett, Dr C Murtagh
Galway Hospice Foundation

Background

A crisis pack, of one or more medications, is prescribed in anticipation of a terminal haemorrhage with the goal of alleviating patient distress[1].

A challenge in the prescription and administration of crisis packs is the lack of data to allow for evidence-based management. The literature published is largely case reports. Hence, there is significant variability in which medications are used, including which dosage and route[1].

Objectives

Establish current practice among senior palliative medicine physicians in the Republic of Ireland (ROI), regarding anticipatory prescribing to manage a terminal hemorrhage.

Generate a guideline informed by data collected.

Methods

An electronic questionnaire was sent to palliative medicine consultants and specialist registrars in the ROI.

Data was analysed using the online survey software and excel.

Results

- The questionnaire was sent to 96 individuals with a 50% response rate.
- 100% of participants prescribed crisis packs.
- The most prescribed medications were morphine and midazolam (Figure 1). Of those that selected "Other" 9 referenced the use another opioid, one phenobarbitone and one commented that they used to prescribe both morphine and midazolam but now only midazolam.

Figure 1. Medication Prescribed

- Over 95% prescribed medication via the subcutaneous route.
- Most participants (70.8%) vary the dose of crisis medication charted based on if the patient is on a baseline anxiolytic and/or opioid.
- The calculations used for dose variation were inconsistent between participants (Table 1)
- Almost one third prescribed 1/6 of the total 24-hour dose.

Calculation used relative to fracture 24-hour opioid dose (relative to typical breakthrough opioid dose)	Number of participants n= 31 (%)
1/6	10 (32.3%)
More than 1/6 (but no further details of exact calculation)	4 (12.9%)
1/4	1 (3.2%)
1/3	6 (19.4%)
2/3	2 (6.5%)
No definitive calculation provided	8 (25.8%)

Table 1. Calculations used for prescribing opioid in crisis pack.

- The most common inclusion criterion for prescribing by malignancy type was head and neck cancer (Figure 2).
- Of the 81.3% who provided additional information regarding inclusion criteria most of the extra detail was related to assessing an individual patient's bleed risk.

Figure 2 Inclusion Criteria

- Almost 2/3 of participants did not follow any guideline or policy when prescribing (Table 2).

Policy or Guideline Followed	Number of participants N = 48 (%)
None	30 (65.2%)
Own hospital/hospice	11 (23.9%)
Another organisation/publication	6 (13.0%)
Did not answer	1 (2.2%)

Table 2. Prescribing Policy or Guideline Used

- The guideline generated from the data is shown in Figure 3.
- The prescribing recommendations vary depending on whether the patient is in a healthcare setting or at home.

Figure 3. Crisis Pack Prescribing Guideline

1. Patient is for full resuscitation in the event of a bleed
Yes → Do not prescribe crisis pack
No → 2. Patient fulfills at least one of the below criteria:
High risk of bleed due to tumor location* or haematological** factors
Prior bleeding or active small volume bleeding at tumor site
No → Do not prescribe crisis pack
Yes → 3. Where is patient located?
At home → Patient is on a baseline benzodiazepine and/or opioid
Yes → Calculate 24-hour i) benzodiazepine dose (equivalent to midazolam) ii) opioid dose (equivalent to morphine)
24-hour dose is midazolam and/or morphine> 60mg → Prescribe crisis pack as midazolam and morphine S/C 1/6 of either respective total daily doses ***
24-hour dose is < 60mg midazolam and morphine → Prescribe crisis pack as midazolam and morphine 10mg S/C***
No → Prescribe crisis pack as midazolam and morphine 10mg S/C***
Medical Facility (e.g. hospice, hospital or nursing home) → Patient is on a baseline benzodiazeoine
Yes → Calculate 24-hour benzodiazepine dose (equivalent to midazolam)
24-hour dose is midazolam > 60mg → Prescribe crisis pack as midazolam transbuccal 1/6 of total daily dose ***
24-hour dose is < 60mg midazolam → Prescribe crisis pack as midazolam 10mg transbuccal***
No → Prescribe crisis pack as midazolam 10mg transbuccal***

* High risk of bleeding due to tumor location such as proximity to major vasculature on imaging or an ulcerating/fungating lesion that is clinically close to major vasculature (such as a head and neck tumor).
** High risk of bleeding due to haematological factors such as thrombocytopaenia (platelets < 10), disseminated intravascular coagulation, liver failure
*** If a crisis pack is prescribed the indication and the medication prescribed should be documented in the medical notes.

Discussion

The results of the study demonstrate that there is little variation in the medications or route prescribed. From the survey the area of variation is the dose prescribed for those who are on a background opioid. Doses ranged between using 1/6 the total daily dose to up to 4 times the breakthrough dose.

The results are at variance with the Specialist Palliative Care Audit and Guidelines Group guidelines[2] in which 10mg of IM midazolam is recommended.

To standardise crisis pack prescribing a guideline should be used. This guideline (Figure 3) is based on the expert opinion of the survey participants.

Limitations:
- The lack of any validated questionnaire available for crisis pack prescribing.
- The possibility of responder bias, as all participants prescribed crisis packs.

Strengths:
- The response rate of 50% is higher than the reported online questionnaire average of 44.1%[3].
- To our knowledge this is also the largest published survey of prescribing practices for crisis packs.

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Title:	Crisis Pack Prescribing in Terminal Haemorrhage: A National Survey of Specialist Palliative Medicine Physicians
Authors:	Kennedy, Manktelow, Harnett, Murtagh

Research

The Intersection of Geriatric Oncology and Palliative Care- Analysis of Local Referral Pathways

Dr Jane McSweeney, Dr Denise Hayes, Dr Anne Horgan
University Hospital Waterford

Background

Cancer is a significant health concern for older people, and decisions in relation to systemic anti-cancer treatment (SACT) in those over 65years become more complex as the number of co-morbidities and incidence of frailty rise. The local Geriatric Oncology Assessment and Liaison Clinic (GOAL) is the first of its kind in Ireland. The GOAL database contains clinical, demographic, and age-specific information which are indicators of frailty. This information is used to determine suitability for SACT.

Early integration of Palliative Care is known to improve quality of life for patients with cancer. At present there is no formal link between the Specialist Palliative Care (SPC) Service and the GOAL clinic. We wished to examine the extent to which our services share this patient cohort, and to determine the characteristics of those patients known to both. This forms the first step in a movement towards a formalised link between GOAL Service and Specialist Palliative Care in University Hospital Waterford.

Aims

1. To identify patients common to GOAL clinic and Specialist Palliative Care (SPC) services in an Irish county.
2. Describe the characteristics of this patient cohort.
3. Examine referral pathways, timing of referrals to SPC, and place of death for patients in this group.

Methods

This is a descriptive retrospective cross-sectional review.

Ethical approval was granted by Regional Ethics Committee.

Patients referred to both GOAL and SPC services in Waterford city and county from 01/01/2020 to 31/12/2023 were identified by manual search of both databases.

Excel software used to collect and analyse pseudo-anonymized demographic, clinica, and age-specific data.

Results

There were 81 patients registered to a Waterford City or County address on the GOAL database. Of these patients 41 were also registered on Specialist Palliative Care database. In total there were 23 males and 18 females. Min age 70; max age 90; median 78 SD 5.47years. There were 16 male patients offered SACT following initial GOAL assessment (mean age 78.6); and 8 females (mean age 75). The mean age for males not offered SACT was 81 years (n=8); Female not offered SACT was 78.6 years (n=9).
The mean number of medications for SACT group was 7.65 (SD 3.55), and 9.83 (SD 3.8) for those not offered SACT. 91% of patients had 3 or more co-morbidities, there was no meaningful difference between the two groups.

Figure 1: Source of referral

Examination of timing of referrals revealed that the mean interval from GOAL assessment to SPC referral was 241 days. Mean interval from SPC referral to death was 140 days.

Limitations

The chief limitation of this review is the small sample size. This initial phase was limited to a relatively small geographical area due to practical and logistical issues in accessing Community Palliative Care data from outside the county.

Conclusions

Given the significant proportion of patients known to both services, and the general risk profile of this group of patients, there is certainly scope to achieve a greater degree of early Palliative Care involvement for patients referred to GOAL service.
GOAL patients offered chemotherapy may be more likely to require end of life care in the hospice or acute hospital setting than those who are not treated. This may be a reflection of higher symptom complexity, or on a greater emphasis on pursuing reversibility.
A larger sample size will be required to determine statistical significance, and to identify potential triggers for SPC referral in the future. Ethical approval has been granted, and data collection is underway.

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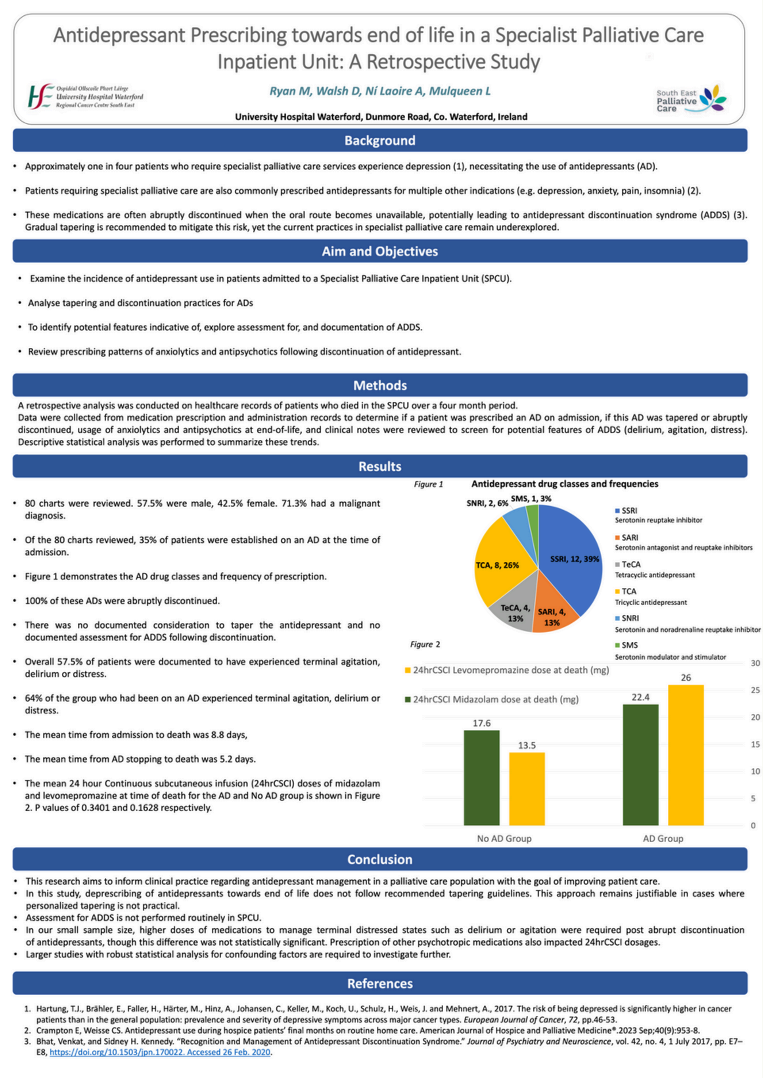
Title: The intersection of Geriatric Oncology and Palliative Care- Analysis of Local Referrals

Authors: McSweeney, Hayes, Horgan

Research



Antidepressant Prescribing towards end of life in a Specialist Palliative Care Inpatient Unit: A Retrospective Study

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Background

- Approximately one in four patients who require specialist palliative care services experience depression (1), necessitating the use of antidepressants (AD).
- Patients requiring specialist palliative care are also commonly prescribed antidepressants for multiple other indications (e.g. depression, anxiety, pain, insomnia) (2).
- These medications are often abruptly discontinued when the oral route becomes unavailable, potentially leading to antidepressant discontinuation syndrome (ADDS) (3). Gradual tapering is recommended to mitigate this risk, yet the current practices in specialist palliative care remain underexplored.

Aim and Objectives

- Examine the incidence of antidepressant use in patients admitted to a Specialist Palliative Care Inpatient Unit (SPCU).
- Analyse tapering and discontinuation practices for ADs
- To identify potential features indicative of, explore assessment for, and documentation of ADDS.
- Review prescribing patterns of anxiolytics and antipsychotics following discontinuation of antidepressant.

Methods

A retrospective analysis was conducted on healthcare records of patients who died in the SPCU over a four month period.
Data were collected from medication prescription and administration records to determine if a patient was prescribed an AD on admission, if this AD was tapered or abruptly discontinued, usage of anxiolytics and antipsychotics at end-of-life, and clinical notes were reviewed to screen for potential features of ADDS (delirium, agitation, distress). Descriptive statistical analysis was performed to summarize these trends.

Results

- 80 charts were reviewed. 57.5% were male, 42.5% female. 71.3% had a malignant diagnosis.
- Of the 80 charts reviewed, 35% of patients were established on an AD at the time of admission.
- Figure 1 demonstrates the AD drug classes and frequency of prescription.
- 100% of these ADs were abruptly discontinued.
- There was no documented consideration to taper the antidepressant and no documented assessment for ADDS following discontinuation.
- Overall 57.5% of patients were documented to have experienced terminal agitation, delirium or distress.
- 64% of the group who had been on an AD experienced terminal agitation, delirium or distress.
- The mean time from admission to death was 8.8 days,
- The mean time from AD stopping to death was 5.2 days.
- The mean 24 hour Continuous subcutaneous infusion (24hrCSCI) doses of midazolam and levomepromazine at time of death for the AD and No AD group is shown in Figure 2. P values of 0.3401 and 0.1628 respectively.

Figure 1 **Antidepressant drug classes and frequencies**

Figure 2

Conclusion

- This research aims to inform clinical practice regarding antidepressant management in a palliative care population with the goal of improving patient care.
- In this study, deprescribing of antidepressants towards end of life does not follow recommended tapering guidelines. This approach remains justifiable in cases where personalized tapering is not practical.
- Assessment for ADDS is not performed routinely in SPCU.
- In our small sample size, higher doses of medications to manage terminal distressed states such as delirium or agitation were required post abrupt discontinuation of antidepressants, though this difference was not statistically significant. Prescription of other psychotropic medications also impacted 24hrCSCI dosages.
- Larger studies with robust statistical analysis for confounding factors are required to investigate further.

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Title: Antidepressant Prescribing towards end of life in Specialist Palliative Care Inpatient Unit: A Retrospective Study

Authors: Ryan, Walsh, Ni Laoire, Mulqueen

Research

Exploring the potential value of weight-based opioid prescribing- a systematic review of the literature

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Background: The potential role for weight-based opioid prescribing in palliative care is presently unclear, hence the potential benefit of carrying out further research into this topic. We carried out a systematic review of the present literature.

Aim: There is a dearth of research on weight-based opioid prescribing in the palliative care setting, and particularly in the cases of extremes of body weight. It is of integral importance that each patient receives the appropriate opioid dose to optimally manage their pain, and given that both underdosing and overdosing have negative repercussions for the patient. Hence this systematic review will help examine the current gap in the literature on this topic.

Methods: In October 2024, the PubMed database was used to perform a search, in order to compile articles for this systematic review.

Findings/ Result:, Sahar M et al published an article entitled *"Weight- Versus Non-Weight-Based Continuous-Infusion Fentanyl Dosing Regimen in Critically Ill Adults"* in *Critical Care Medicine* (2021) They found that in a study of 60 patients in intensive care on mechanical ventilation, receiving fentanyl via continuous subcutaneous infusion (CSCI), those whose opioid dosage was non-weight based received significantly less opioid than those whose dose was calculated based on weight. Patients on the non-weight based Fentanyl CSCI regime required increased amounts of adjuvant daily opioid.

A study by Xia S. et al (2014) showed that analgesic response to one milligram of hydromorphone intravenously did not vary by total body weight, thereby suggesting no clear benefit of weight-based doses over fixed opioid doses.

De Hoogd et al (2017) found that morphine metabolism was not altered in patients who were morbidly obese and that morphine concentrations were unchanged between morbidly obese patients and those with a normal body mass index, indicating no necessity for weight-based dose adjustments of opioids.

The majority of articles on this topic suggest there is no requirement for weight-based opioid prescribing.

Conclusion: whilst the literature available would suggest there is no role for weight-based opioid dosing, the research is very limited, especially within the palliative care setting. Hence the possible value in further exploring this area.

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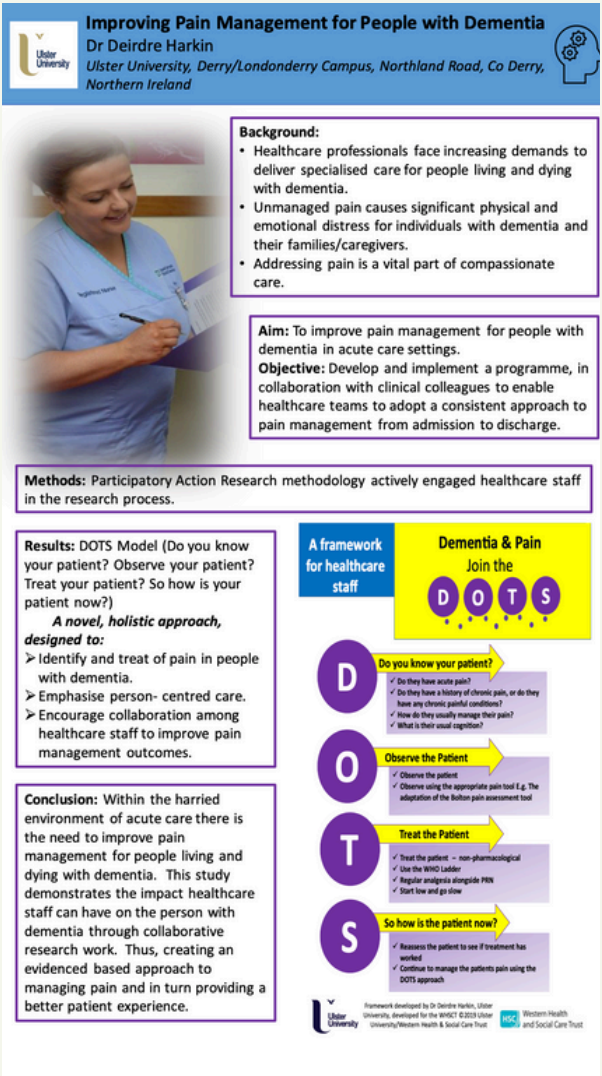
Title: Exploring potential value of weight-based opioid prescribing – a systematic review

Authors: McDonnell, Waldron, Keane, Kelly, Reilly, Gaffney, Cronin

Research



Improving Pain Management for People with Dementia

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Background:

- Healthcare professionals face increasing demands to deliver specialised care for people living and dying with dementia.
- Unmanaged pain causes significant physical and emotional distress for individuals with dementia and their families/caregivers.
- Addressing pain is a vital part of compassionate care.

Aim: To improve pain management for people with dementia in acute care settings.
Objective: Develop and implement a programme, in collaboration with clinical colleagues to enable healthcare teams to adopt a consistent approach to pain management from admission to discharge.

Methods: Participatory Action Research methodology actively engaged healthcare staff in the research process.

Results: DOTS Model (Do you know your patient? Observe your patient? Treat your patient? So how is your patient now?)

A novel, holistic approach, designed to:

- Identify and treat of pain in people with dementia.
- Emphasise person- centred care.
- Encourage collaboration among healthcare staff to improve pain management outcomes.

Conclusion: Within the harried environment of acute care there is the need to improve pain management for people living and dying with dementia. This study demonstrates the impact healthcare staff can have on the person with dementia through collaborative research work. Thus, creating an evidenced based approach to managing pain and in turn providing a better patient experience.

A framework for healthcare staff

Dementia & Pain
Join the
D O T S

D — Do you know your patient?
- ✓ Do they have acute pain?
- ✓ Do they have a history of chronic pain, or do they have any chronic painful conditions?
- ✓ How do they usually manage their pain?
- ✓ What is their usual cognition?

O — Observe the Patient
- ✓ Observe the patient
- ✓ Observe using the appropriate pain tool E.g. The adaptation of the Bolton pain assessment tool

T — Treat the Patient
- ✓ Treat the patient – non-pharmacological
- ✓ Use the WHO Ladder
- ✓ Regular analgesia alongside PRN
- ✓ Start low and go slow

S — So how is the patient now?
- ✓ Reassess the patient to see if treatment has worked
- ✓ Continue to manage the patients pain using the DOTS approach

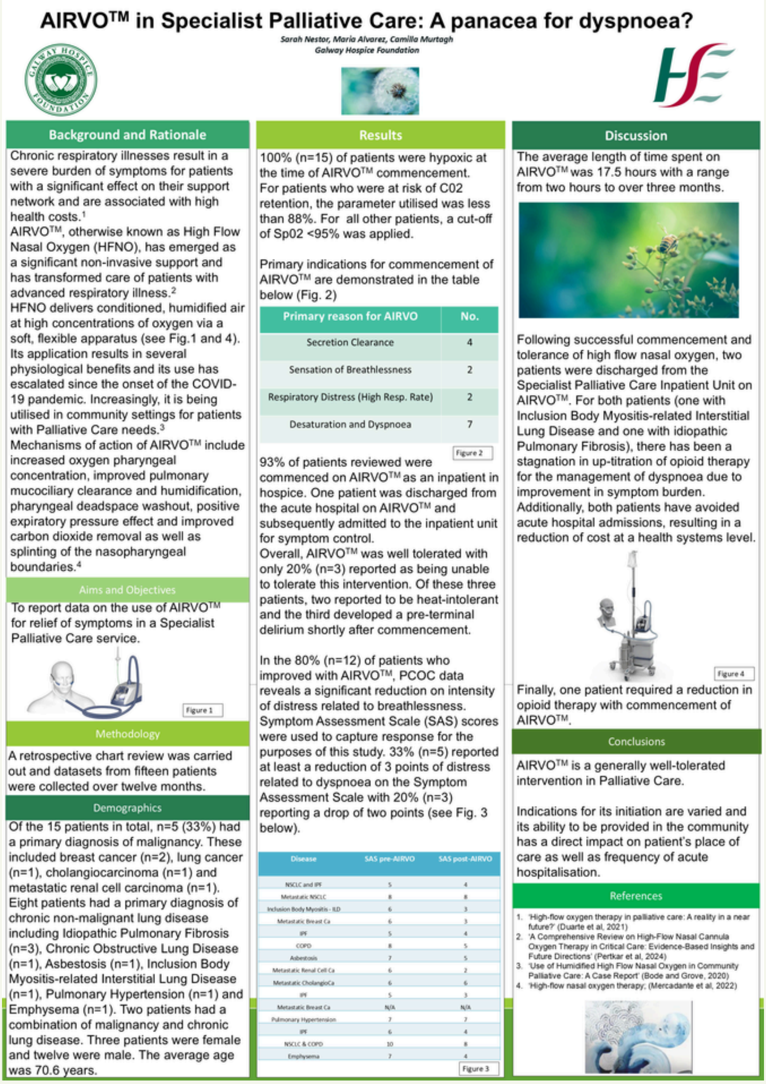
Framework developed by Dr Deirdre Harkin, Ulster University, developed for the WHSCT ©2019 Ulster University/Western Health & Social Care Trust

Western Health and Social Care Trust

Title: Improving pain management for people with dementia

Authors: Harkin

Research



AIRVO^{TM} in Specialist Palliative Care: A panacea for dyspnoea?

Sarah Nestor, Maria Alvarez, Camilla Murtagh
Galway Hospice Foundation

Background and Rationale

Chronic respiratory illnesses result in a severe burden of symptoms for patients with a significant effect on their support network and are associated with high health costs.[1]
AIRVO^{TM}, otherwise known as High Flow Nasal Oxygen (HFNO), has emerged as a significant non-invasive support and has transformed care of patients with advanced respiratory illness.[2]
HFNO delivers conditioned, humidified air at high concentrations of oxygen via a soft, flexible apparatus (see Fig.1 and 4). Its application results in several physiological benefits and its use has escalated since the onset of the COVID-19 pandemic. Increasingly, it is being utilised in community settings for patients with Palliative Care needs.[3]
Mechanisms of action of AIRVO^{TM} include increased oxygen pharyngeal concentration, improved pulmonary mucociliary clearance and humidification, pharyngeal deadspace washout, positive expiratory pressure effect and improved carbon dioxide removal as well as splinting of the nasopharyngeal boundaries.[4]

Aims and Objectives

To report data on the use of AIRVO^{TM} for relief of symptoms in a Specialist Palliative Care service.

Figure 1

Methodology

A retrospective chart review was carried out and datasets from fifteen patients were collected over twelve months.

Demographics

Of the 15 patients in total, n=5 (33%) had a primary diagnosis of malignancy. These included breast cancer (n=2), lung cancer (n=1), cholangiocarcinoma (n=1) and metastatic renal cell carcinoma (n=1). Eight patients had a primary diagnosis of chronic non-malignant lung disease including Idiopathic Pulmonary Fibrosis (n=3), Chronic Obstructive Lung Disease (n=1), Asbestosis (n=1), Inclusion Body Myositis-related Interstitial Lung Disease (n=1), Pulmonary Hypertension (n=1) and Emphysema (n=1). Two patients had a combination of malignancy and chronic lung disease. Three patients were female and twelve were male. The average age was 70.6 years.

Results

100% (n=15) of patients were hypoxic at the time of AIRVO^{TM} commencement. For patients who were at risk of C02 retention, the parameter utilised was less than 88%. For all other patients, a cut-off of Sp02 <95% was applied.

Primary indications for commencement of AIRVO^{TM} are demonstrated in the table below (Fig. 2)

Primary reason for AIRVO	No.
Secretion Clearance	4
Sensation of Breathlessness	2
Respiratory Distress (High Resp. Rate)	2
Desaturation and Dyspnoea	7

Figure 2

93% of patients reviewed were commenced on AIRVO^{TM} as an inpatient in hospice. One patient was discharged from the acute hospital on AIRVO^{TM} and subsequently admitted to the inpatient unit for symptom control.
Overall, AIRVO^{TM} was well tolerated with only 20% (n=3) reported as being unable to tolerate this intervention. Of these three patients, two reported to be heat-intolerant and the third developed a pre-terminal delirium shortly after commencement.

In the 80% (n=12) of patients who improved with AIRVO^{TM}, PCOC data reveals a significant reduction on intensity of distress related to breathlessness. Symptom Assessment Scale (SAS) scores were used to capture response for the purposes of this study. 33% (n=5) reported at least a reduction of 3 points of distress related to dyspnoea on the Symptom Assessment Scale with 20% (n=3) reporting a drop of two points (see Fig. 3 below).

Disease	SAS pre-AIRVO	SAS post-AIRVO
NSCLC and IPF	5	4
Metastatic NSCLC	8	8
Inclusion Body Myositis - ILD	6	3
Metastatic Breast Ca	6	3
IPF	5	4
COPD	8	5
Asbestosis	7	5
Metastatic Renal Cell Ca	6	2
Metastatic CholangioCa	6	6
IPF	5	3
Metastatic Breast Ca	N/A	N/A
Pulmonary Hypertension	7	7
IPF	6	4
NSCLC & COPD	10	8
Emphysema	7	4

Figure 3

Discussion

The average length of time spent on AIRVO^{TM} was 17.5 hours with a range from two hours to over three months.

Following successful commencement and tolerance of high flow nasal oxygen, two patients were discharged from the Specialist Palliative Care Inpatient Unit on AIRVO^{TM}. For both patients (one with Inclusion Body Myositis-related Interstitial Lung Disease and one with idiopathic Pulmonary Fibrosis), there has been a stagnation in up-titration of opioid therapy for the management of dyspnoea due to improvement in symptom burden. Additionally, both patients have avoided acute hospital admissions, resulting in a reduction of cost at a health systems level.

Figure 4

Finally, one patient required a reduction in opioid therapy with commencement of AIRVO^{TM}.

Conclusions

AIRVO^{TM} is a generally well-tolerated intervention in Palliative Care.

Indications for its initiation are varied and its ability to be provided in the community has a direct impact on patient's place of care as well as frequency of acute hospitalisation.

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Title: AIRVOTM in Specialist Palliative Care: A panacea for dyspnoea?

Authors: Nestor

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IAPC would like to gratefully acknowledge the funding received through the Hospital Saturday fund to support the 2025 Seminar.

The IAPC have teamed with BMJ SPC for the last four years where the winner of the platform presentation is invited to submit their research (where appropriate) and have it published by BMJ SPC. We will continue to work with BMJ SP for 2025. This is a prestigious award and we are grateful to Dr. Declan Walsh for continuing to support this initiative.

IAPC

Irish Association For Palliative Care

A Collective Voice for Palliative Care in Ireland since 1993

Established in 1993 as an all-island body with the purpose of promoting palliative care nationally and internationally, the Irish Association for Palliative Care (IAPC) is a multidisciplinary membership non-government organisation. The intention of the founders was that IAPC would be identified by its inclusiveness and would encompass the whole island of Ireland.

The IAPC membership reflects the entire spectrum of all those who work in or have a professional interest in the provision of palliative care. This includes doctors, nurses, social workers, chaplains and pastoral carers, pharmacists, psychologists, physiotherapists, occupational therapists, dietitians, as well as executive staff, academics and educators. Membership also includes clinicians and allied health professionals working in related are as such as geriatrics, oncology, psycho-oncology, paediatrics, and pain management.

The IAPC is organised around a number of working groups designed to create forums aimed at promoting best practice, professional development, research and learning in palliative care.education and research.

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