



Irish Association For Palliative Care
25th Education and Research Seminar

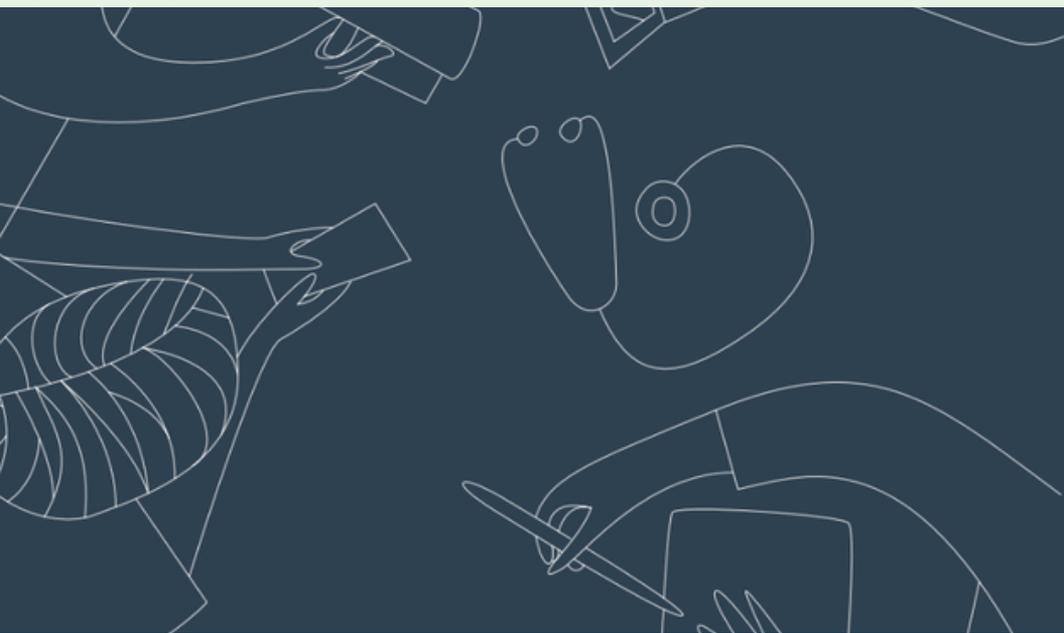
One Goal, One Team:

Advancing Palliative Care Through Inter Disciplinary Collaboration

6th February 2026



Irish Association For Palliative Care
A Collective Voice for Palliative Care in Ireland since 1993



Case Reports 1-9

Case series of the usefulness and tolerability of clonidine in managing complex symptoms in children with Severe Neurological Impairment

C.M. Stephens¹, F. O'Mahony^{1,2}, M. Devins^{3,4}, J. Allen^{1,4,5}

1. Department of Palliative Care, Children's Health Ireland 2. St Luke's Radiation Oncology Network, Highfield Road, Rathgar, Dublin
3. The Coombe Hospital, Cork Street, Dublin 8. 4. The National Maternity Hospital, Holles Street, Dublin.
5. Discipline of Paediatrics, Trinity College Dublin, the University of Dublin, College Green, Dublin 2.



BACKGROUND:

- Clonidine, an α_2 adrenergic receptor agonist (Figure 1), is increasingly used in children.
- It can be administered via several routes including, enteral, intranasal, transdermal, intravenous and subcutaneous.
- In children with Severe Neurological Impairment (SNI), Clonidine is used to manage pain, dystonia, autonomic dysfunction, and irritability.
- It is generally well tolerated in this patient profile.
- This case series highlights its role in managing complex symptoms in a palliative context.

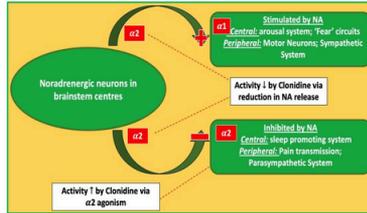


Figure 1: Sites of Action of Clonidine

CASE PRESENTATION 1:



- 8 year ♀ with SNI.
- Hypoxic Ischaemic Encephalopathy (HIE), epilepsy, scoliosis, colitis, PEJ feeds, and gut dystonia.
- Dystonic episodes associated with diaphoresis, tachycardia, pupillary changes and significant distress.
- Gut dystonia led to irritability, feed intolerance, and bowel changes, exacerbating episodes.
- Regular medications included Amitriptyline, Clonazepam, Pregabalin, Baclofen, Nabilone, Omeprazole, Famotidine, Buprenorphine, and Clonidine.



CASE PRESENTATION 2:



- 4 year ♂ with SNI
- Prematurity, cerebral palsy, epilepsy, PEG feeds
- Evolving gut failure on the background of severe dystonia.
- Repeated admissions to PICU for status dystonia.
- Regular medications included Pregabalin, Nabilone, and Clonidine.



MANAGEMENT AND OUTCOMES:

- **Case 1:** Clonidine up-titrated to 33 mcg/kg/day, administered via transdermal, intravenous, subcutaneous, PEJ, and intranasal routes depending on symptoms and access.
- **Case 2:** Clonidine up-titrated to a maximum dose of 51mcg/kg/day. This dose was safely tolerated, administered via parenteral and transdermal routes.
- Both children tolerated escalation across multiple routes with good symptom control.

DISCUSSION:

- Starting doses of Clonidine are described in paediatric drug formularies; maximum of 20mcg/kg/day.
- Experience from our centre demonstrate that higher doses are safe and effective in the paediatric population with multiple routes of administration available, with a 1:1 conversion rate across all routes.

CONCLUSIONS:

- Clonidine is well tolerated and effective in managing complex symptoms with multiple routes of administration available.
- These cases demonstrate the effective use of increasing doses of Clonidine via multiple administration routes beyond standard guidelines, expanding therapeutic options for managing severe paediatric dystonia and associated symptoms.

Title: Case series of usefulness and tolerability of clonidine in managing complex symptoms in children with Severe Neurological Impairment.

Authors: Stephens, O Mahony, Devins, Allen

Case Reports 1-9



Saint Luke's
Radiation Oncology
Network

Nebulised Adrenaline for Stridor: AIR-IN

Dr. Frances O'Mahony, Dr. Declan Fitzpatrick, Ms. Corinna Johnston,
Ms. Sarah-Jane Slattery, Ms. Michelle Jennings, Ms. Marie Doyle,
Dr. Maeve O'Reilly, Dr. Marie Twomey

Introduction

Adrenaline is widely recognised as an emergency treatment for acute laryngeal oedema, particularly in children.

"As an alpha-receptor agonist, adrenaline reverses peripheral vasodilatation and reduces tissue oedema. Its beta-receptor activity dilates the bronchial airways, increases the force of myocardial contraction, and suppresses histamine and leukotriene release"

Resuscitation Council UK

While usually given IM or IV, adrenaline may also be given via a nebuliser as an adjunct. There is limited evidence to support the use of nebulised adrenaline for symptom relief in adults with laryngeal oedema.

We describe a case of a gentleman with stridor due to laryngeal oedema who was treated effectively with nebulised adrenaline.

Evaluation

We did not detect any adverse effects:

- Dr. Fitzpatrick had tachycardia and tremor at baseline due to his existing treatments, which did not deteriorate with nebulised adrenaline.
- His blood pressure remained stable.
- While hyperactivity has been reported in children, Dr Fitzpatrick felt able to engage in more activity due to better symptom control, without objective or subjective agitation.

AIR-IN created positive pressure, with time to cognitively cue his breath independently and to prepare breath technique. This improved dose delivery to the target area (upper airway tract), minimizing nasopharyngeal deposition.

Due to the pressures generated with inhaler and nebuliser devices, it is unlikely that his technique had any impact on drug deposition to the lower airways.

AIR-IN Step 1: Against Resistance



Challenge

Dr Fitzpatrick developed bilateral partial vocal cord palsy with oedema following radical radiotherapy to a recurrent throat cancer, due to chronic effects of prior radiotherapy for his initial presentation a number of years earlier.

This led to progressive airway narrowing with stridor. We agreed not to pursue tracheostomy and to focus primarily on quality of life.

Dr. Fitzpatrick's condition deteriorated with dyspnoea, secretions, increased respiratory effort and desaturations.

- Interventions included:
- Saline and bronchodilator nebulisers
 - Dexamethasone 8mg bid IV
 - Sustained release and prn opioid
 - Misting sprays to cool the face
 - Furosemide prn
 - Antibiotics when indicated

Outcome

With improving respiratory symptoms, Dr Fitzpatrick regained some independence in communication and mobility.

He was referred to hospice, where he could play music and meet friends and continue to have ongoing symptom support.

He died peacefully a few weeks later.

We are indebted to Dr. Fitzpatrick for allowing and encouraging us to share his story, his image and his ideas.

In his own words:

Declan's Tip: AIR-IN Augmented Initial Resistance - In Nebuliser

Several times in a session on the nebuliser, initially partially block (left) the 'inlet/outlet' part of the mouthpiece with your finger and begin inspiration against resistance.

Once a reasonable negative pressure is achieved release (right) the finger and there should be a 'flood' of the active ingredient to deeper into the respiratory tree, reducing the effect of 'dead-space' wastage.

It also gives some symptomatic relief to the sensation of not being able to inflate the lungs and leaves less of a taste in the mouth. Over time this might have beneficial effects.

Intervention

Dr. Fitzpatrick's stridor continued to deteriorate and a novel therapy was considered for symptom control.

Nebulised Adrenaline:

1 in 1000 ampule (1 ampule = approx. 1mg) drawn up to 5ml with 0.9% Normal Saline nebulised via a mouthpiece up to qds

After a test dose, Dr. Fitzpatrick felt immediate relief and requested it regularly, due to its short duration of effect.

He developed a technique (AIR-IN) to optimise delivery of the medicine and took 1-2 breaths as needed, rather than nebulising the full volume in one sitting.

Conclusion

This case describes the successful application of an intervention, which is common in the paediatric setting, for an adult with laryngeal oedema due to complications of cancer and radiotherapy.

The addition of nebulised adrenaline, within a multimodal pharmacological and non-pharmacological regimen, improved symptom control and quality of life for this gentleman.

Further studies, including those exploring safety and efficacy, are needed to determine if this intervention should be used more widely in the adult setting.

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The Use of Nebulised Adrenaline by Tracheal Stridor. Pharmacy Department, Our Lady's Hospital and Care Services 2019
McDonald SP, Timony AC, Wilson JD. Adrenaline administered via a nebuliser in adult patients with upper airway obstruction. Anaesthesia 1999 Jan;52(1):24-6. doi: 10.1111/1365-2040.1999.01702.x

AIR-IN Step 2: Release



Title: Nebulised Adrenaline for Stridor: AIR-IN

Authors: O Mahony, Johnston, Slattery, Jennings, Doyle, O'Reilly, Twomey

Case Reports 1-9

The Lazarus Effect: Opioid Toxicity Masquerading as Terminal Decline

T. CAHILL¹, H. MYLES¹

¹MILFORD CARE CENTRE, LIMERICK, IRELAND



BACKGROUND

- Opioids are central to the management of cancer-related pain but carry a risk of opioid toxicity (OT), particularly in the context of intercurrent illness, infection, or physiological deterioration.
- In palliative care, OT may closely resemble terminal decline, presenting with progressive somnolence, respiratory depression, reduced oral intake, and neuromuscular features such as myoclonus.
- This diagnostic overlap poses significant challenges and may lead to missed opportunities for reversal of a treatable condition.

CASE PRESENTATION



- 62 year old female nursing home resident with metastatic pancreatic cancer
- Known to Community Palliative Care (CPC) team
- Complex cancer-related pain managed with modified-release oral oxycodone (50mg bd po).
- Over 48 hours developed:
 - Increasing drowsiness and reduced responsiveness
 - Reduced respiratory rate (RR)
 - Poor oral intake
 - Myoclonus
- CPC team contacted due to concern that patient was entering the terminal phase

Management and Outcomes

- The patient was transferred to an inpatient hospice unit for further assessment. Clinical evaluation raised a high index of suspicion for opioid toxicity (GCS 3, RR 2 = breaths per minute, Oxygen saturation 84% on room air), with possible contribution from aspiration pneumonia.
- An initial intravenous naloxone bolus of 80 micrograms resulted in rapid improvement in consciousness, followed by recurrence of symptoms. Four further boluses were administered, with similar effect over a 6 hour period.
- Decision was made to commence a continuous naloxone infusion until there was a 2 hour period of RR >8 and sustained alertness.
- Intravenous antibiotics (IVA) were initiated for presumed aspiration pneumonia along with intravenous fluids. Nocte medications were held.
- The patient demonstrated sustained clinical improvement, with recovery of consciousness and respiratory function.
- Continued on course of IVA for one week. Commenced on a continuous subcutaneous Alfentanil infusion to manage pain before subsequent rotation to oral opioids.
- Methadone was added as an adjunct for complex pain control.
- Patient discharged back to the nursing home for ongoing care 3 weeks after initial presentation.

DISCUSSION



- Opioid toxicity is likely under-recognised in palliative care due to overlap with features commonly associated with the terminal phase of illness.
- Intercurrent infection and physiological stress may reduce opioid clearance and increase central nervous system sensitivity, precipitating toxicity even in the absence of recent dose escalation.
- This case emphasises the importance of ongoing clinical reassessment and the need to actively consider reversible causes when deterioration occurs.
- Naloxone can be used safely in palliative care when administered in low, titrated doses, and continuous infusion may be required to maintain reversal while minimising the risk of acute pain or withdrawal.

CONCLUSION

- Opioid toxicity is a reversible medical emergency that can present subtly in palliative care populations.
- Early recognition and appropriate naloxone use, including infusion protocols, can significantly alter outcomes and prevent inappropriate end-of-life escalation.

CONTRIBUTION TO PRACTICE

- This case prompted a review of local hospice naloxone guidance.
- Updated protocols now include clear indications for naloxone use in palliative care, guidance on infusion therapy, and emphasis on reassessment of potentially reversible causes of deterioration.
- These changes aim to improve clinical confidence and patient safety.

References:



Title: The Lazarus Effect: Opioid Toxicity Masquerading as Terminal Decline

Authors: Cahill, Myles

Case Reports 1-9

A Case of Recurrent Metastatic Adenoid Cystic Carcinoma in a Neurodivergent Patient

Authors

1. Dr. Anna Hayes - St Francis Hospice, Dublin
2. Dr. Val O'Reilly - St Francis Hospice, Dublin



St. Francis Hospice

Background

- Many autistic adults without intellectual disability experience patient, provider and system level barriers to accessing and navigating healthcare.
- Difficulties reported include feeling misunderstood and encountering services that do not accommodate communication differences, anxiety or sensory sensitivities.
- Alexithymia, characterised by difficulty identifying and describing emotions and bodily states, can impair symptom reporting and contribute to unmet healthcare need.
- Healthcare environments may intensify these challenges through sensory overload, time-pressured consultations, limited continuity of care and variable clinician understanding of autism.
- Reduced informal support networks further increase vulnerability, particularly during serious illness.
- Recognition of autism within healthcare is essential to avoid misinterpretation of behaviours, delayed help-seeking and inequitable care (1,2).

Adenoid cystic carcinoma

- Rare secretory gland malignancy (~1% head & neck, ~10% salivary)
- Brain metastases uncommon, usually via perineural cranial spread
- No standard systemic therapy; high rates of late recurrence (3)



Image 1: MRI brain

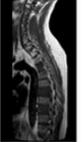


Image 2: MRI spine

Case presentation

- A 40-year-old man was diagnosed with right parotid gland adenoid cystic adenocarcinoma and treated with parotidectomy followed by adjuvant radiotherapy.
- Traits of neurodiversity were evident during consultations, with maintenance of routine, including employment and niche hobbies, acting as an important protective factor for wellbeing.
- Disease recurrence and progression through multiple treatment lines led to a best supportive care approach, triggering specialist palliative care involvement.
- Escalating thoracic pain was initially under-reported, with the patient independently sourcing positional aids to minimise recumbency, reflecting a strong preference for autonomous problem-solving.
- He later presented with unilateral visual loss. Investigations demonstrated retinal detachment secondary to intraocular metastasis, intracranial disease and extensive axial skeletal metastases.
- Care planning required coordination across multiple sites, with MDT input, particularly occupational therapy, essential in maintaining independence during progressive functional decline, including visual impairment.
- Discussions regarding anticipated loss of function and threats to autonomy were associated with significant distress.

Management and outcomes

- Fragmentation of care and the perceived intensity of multidisciplinary involvement heightened distress.
- Frequent medication changes in response to evolving symptoms disrupted established routines, complicating adherence and engagement and contributing to repeated delays in palliative radiotherapy.
- Progressive clinical deterioration ultimately necessitated admission to inpatient specialist palliative care unit for terminal care.

Learning points

- Delivering palliative care to patients with neurodiversity poses challenges for healthcare professionals & systems, particularly when symptom presentation is atypical.
- Reliance on fixed routines means frequent treatment or medication changes may cause distress, underscoring the need for clear communication, continuity & anticipatory planning.
- Recognition of neurodiverse traits & proactive symptom surveillance are essential to reduce fragmentation, support timely intervention & optimise engagement.
- Multidisciplinary teams are central to holistic, patient-centred care, anticipating evolving needs & supporting decision-making.
- Unmet educational needs within teams require targeted training & system-level adjustments to improve care coordination & effectiveness

Conclusions: This case highlights the importance of recognising neurodiversity in clinical practice & tailoring care to patients' individual needs.



AsIam (Ireland's autism charity) offers trusted, evidence-based guidance & resources to support adults with autism, families, & healthcare professionals.

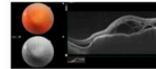


Image 3: Ocular metastasis (4)

Ocular metastases

- Occur in 8–10% of disseminated cancers (commonly breast, lung)
- Usually solitary, unilateral, posterior choroidal lesions
- Visual loss from macular/optic nerve involvement or subretinal fluid
- Management is palliative & vision-preserving (4)

References

1. Rogers C, et al. "It's designed for someone who is not me": A reflexive thematic analysis of the unmet healthcare support needs in UK autistic adults aged 65 years and over. *Autism*. 2023;27(6):1867–1882. PMID: 39470046
2. Moxon S, et al. Recognising autism in healthcare. *BMJ*. 2022;377:e019046. PMID: 3488227
3. Zupancic M, Wilmshurst A, Frieselons S, & Collaris T (2024). Adenoid cystic carcinoma, clinical presentation, current treatment and approaches towards novel therapies. *Anticancer Research*. e1(4): 1215–1216. <https://doi.org/10.28758/anticancer.19159>
4. Shields C, L. Kalki S, Furuta M, et al. (2024). Clinical characteristics and management of ocular metastases. *Ophthalmology*. 131(1), 10–22. <https://doi.org/10.1016/j.ophtha.2023.08.016>

sfh.ie

Title: A Case of Recurrent Metastatic Adenoid Cystic Carcinoma in a Neurodivergent Patient

Authors: Hayes, O' Reilly

Case Reports 1-9

Crushed topical Metronidazole for cavitating malignant abdominal wound malodour

Ryan M, Cunningham J, & Lorton C.
Our Lady's Hospice & Care Services



Background

- Malodour from malignant wounds is a distressing symptom caused by anaerobic bacterial metabolism of necrotic tissue, significantly impairing quality of life.

Case Presentation

- A 68-year-old female with metastatic breast cancer developed a large, fungating abdominal mass.
- Admitted to inpatient unit with wound breakdown and bleeding.
- Managed with dressings and Tranexamic Acid.
- This progressed to deep, cavitating wound (4.5cm×5cm×7cm) with heavy exudate.
- Patient rated malodour 10/10 for intensity and distress.

Management and Outcomes

Standard dressings, systemic antibiotics, and deodorizers failed to control the odour.

400mg of a crushed metronidazole tablet was sprinkled into the wound during daily dressing changes.

- Patient's self reported malodour ratings:
- 3/10 by day two
 - 0/10 by day four
 - Resolution sustained at 73-day follow-up.



Image 1: Picture of patient's wound, used with consent.



Image 2: Cartoon image of Anaerobic bacteria, AI generated.

Discussion

- Direct application of crushed metronidazole provided a high concentration of the antimicrobial agent at the source of the anaerobic infection.
- Crushed option chosen over a gel preparation, as less likely to be diluted and more effective due to the wound's depth and high exudate levels.
- The rapid and sustained response confirms the efficacy of this approach.

Learning Points

- Topical crushed metronidazole is a simple, rapid, and effective intervention for severe malignant wound malodour when conventional methods fail.

What this study adds

- Crushed metronidazole tablets as an alternative to gels for cavitating, highly exudative wounds where gel formulations are unsuitable.

Conclusions

- Direct topical application of crushed metronidazole tablets gave complete and sustained resolution of severe malignant wound malodour.

Contribution to practice and originality

- Adds to scant case reports of crushed metronidazole as a practical palliative care strategy.
- Offers clinicians an additional valuable and effective tool for managing fungating wound malodour.

References

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- Hu JK, Lightberg KG, Laventhal J, Bunick CG. Successful management of malodour from fungating tumors using crushed metronidazole tablets. *JAAD Case Rep*. 2019 Dec 24;6(1):26-29. doi: 10.1016/j.jacr.2019.10.025. PMID: 31909133. PMCID: PMC6938872.
- Paul JC, Pieper BA. Topical metronidazole for the treatment of wound odor: a review of the literature. *Ostomy Wound Manage*. 2008 Mar;54(3):18-27. quiz 28-9. PMID: 18382045.

Title: Crushed topical Metronidazole for cavitating malignant abdominal wound malodour

Authors: Ryan, Cunningham, Lorton

Case Reports 1-9

Title: Quality-Time is brain: Early mortality from an acute stroke in a palliative care unit

Authors: Maguire, Kehoe, Reagan, Sheahan, Neito

Case Reports 1-9

An Uncommon Side Effect: Parotitis Secondary to Glycopyronium

Dr. Mary Kennedy, Professor Andrew Davies



Background

Parotitis refers to inflammation of the parotid glands and represents the most frequently occurring inflammatory disorder of the major salivary glands. The condition can manifest as an isolated local process or as a component of systemic disease. Typically, parotitis presents with pain and unilateral glandular swelling accompanied by diminished salivary secretion.

Acute parotitis commonly results from viral or bacterial pathogens, sialolithiasis, or ductal obstruction. In contrast, chronic parotitis generally stems from autoimmune disorders, recurrent infectious episodes, or structural abnormalities of the gland or ductal system. Several factors increase susceptibility to parotitis, including diabetes mellitus, compromised immune function, inadequate hydration, and the use of medications that suppress salivary production.

Glycopyronium is an antimuscarinic drug which is used to manage respiratory secretions at the end of life and in the palliative management of bowel obstruction. Here we present an uncommon side effect of this commonly used medication.

Case

AB was admitted to the inpatient unit following a diagnosis of malignant bowel obstruction, managed conservatively. Prior to admission, he was started on a continuous subcutaneous infusion (CSI) of octreotide at 1500 mcg over 24 hours and had a nasogastric (NG) tube in place.

On the fifth day of admission, AB experienced worsening nausea accompanied by a high output from his NG tube. His CSI was adjusted to include haloperidol 2.5 mg, glycopyrrolate 2.4 mg, and octreotide 1500 mcg over 24 hours.

That evening, AB developed acute urinary retention, necessitating catheterization. He also reported new onset xerostomia. The volume of output from his NG tube reduced to 0ml/24 hours.

By Day 7, he became unwell and presented with acute, painful, and notable unilateral facial swelling, leading to a clinical diagnosis of bacterial parotitis.

Management

ABs CSI was discontinued and he was commenced on a CSI containing haloperidol 2.5mg only.

IV Co Amoxiclav, IV fluids and PR diclofenac were prescribed. By Day 9 his facial swelling had improved markedly with complete resolution of pain. Clinical examination suggested that ABs bowel obstruction had resolved. His NG tube and urinary catheter were removed with no ill effects observed.

The NG tube was reinserted on Day 20 for the management of nausea and vomiting.

AB died on Day 46 of his admission.

Discussion

Historically, bacterial parotitis was a common complication in dehydrated postoperative patients, especially those with compromised oral hygiene, with *Staphylococcus aureus*, *Streptococcus viridans*, and *Streptococcus pneumoniae* identified as the predominant causative organisms.[1] However, none of these traditional risk factors were present in the patient discussed in this case report.

The only notable therapeutic modification preceding symptom onset was the initiation of subcutaneous antisecretory agents via syringe driver, which induced xerostomia. The most likely mechanism for the development of bacterial parotitis in this patient is that reduced salivary flow compromised the natural protective barrier of the parotid glands, facilitating retrograde bacterial colonization through Stensen's duct.

Although xerostomia-inducing medications are widely suspected as potential risk factors for bacterial parotitis, the medical literature contains no published case reports documenting this association with glycopyronium. Given that somatostatin receptors have not been identified in parotid gland tissue, the observed complication is more plausibly attributed to glycopyronium, which exerts anticholinergic effects on salivary secretion.

When antisecretory medications rapidly result in urinary retention, the concurrent development of severe xerostomia may indicate heightened sensitivity to anticholinergic agents. In such clinical scenarios, dose reduction of the anticholinergic medication may restore adequate salivary gland function and thereby mitigate the risk of ascending bacterial parotitis.

Key Learning Points

1. Antisecretory medications can cause severe xerostomia, predisposing to bacterial parotitis—an unreported association in the literature.
2. Severe drug-induced xerostomia eliminates saliva's protective flushing action, enabling ascending bacterial infection through parotid ducts.
3. Traditional risk factors (dehydration, poor dentition, postoperative state) were absent. Many medications create new risk scenarios beyond classical teaching.
5. Prompt antibiotic therapy (e.g., co-amoxiclav) may achieve rapid resolution of parotitis.
6. Clinicians must balance effective symptom management against complications. Vigilant monitoring of oral health when using antisecretory regimens is required and employing dose titration to optimize comfort while minimizing adverse effects is vital.

Title: An uncommon side effect: Parotitis secondary to glycopyronium

Authors: Kennedy

Case Reports 1-9



A case series on the use of Ketorolac subcutaneous infusion
in a Specialist Palliative Care (SPC) inpatient unit
Dr. Zaheer Kara, Dr. Miriam Colleran, Missy Leeson & Dr. Barbara Sheehy-Skeffington
St. Brigid's Hospice, Co. Kildare



Background: SPC aims to optimise and support whole person care in patients with advanced progressive illnesses. Pharmacological interventions play a key role in the armamentarium of pain management. Recent unavailability of diclofenac led to the use of ketorolac as an alternative. It is 5 times more potent than diclofenac. There are limited case reports of continuous subcutaneous infusion (CSCI) of ketorolac. Ethical review was not sought in this case series.



Case series: 3 patients received ketorolac CSCI from summer 2025 onwards after changing from diclofenac infusions due to bone pain and a lack of availability of diclofenac. These 3 women had an age range of 63-86 years and cancer diagnoses.

Management and Outcomes: To describe the use of Ketorolac CSCI in 3 patients in a SPC inpatient unit. Ketorolac was administered as a single CSCI agent. Normal saline was used as the diluent.

Results: 3 patients received Ketorolac CSCI after changing from diclofenac infusions. Ketorolac was commenced at a dose of 30mg CSCI over 24 hours and increased to 60mg in 3 patients by Day 2, with clinical response to pain within 24 hours of titration to 60mg. All 3 patients had originally been on Diclofenac 150mg CSCI with incomplete analgesic control.



Discussion: Parenteral ketorolac is sold unlicensed at a cost of 9 euro for 5 ampoules of 30mg/ml in Ireland. Injectable diclofenac is sold unlicensed at a cost of 26 euro for 5 ampoules of 75mg/ 3ml.

Conclusion: Ketorolac CSCI was clinically effective in this case series.

Greater study is needed comparing the efficacy and safety of CSCI of Ketorolac with the current CSCI anti-inflammatory of choice, namely, diclofenac.

Contribution: this adds to the paucity of literature on ketorolac CSCI.

email: miriamcc@live.ie

Title: Ketorolac continuous subcutaneous infusions (CSCI) in a Specialist Palliative Care (SPC)

Authors: Kara, Colleran, Leeson, Sheehy-Skeffington

Audits 10-22




Audit of compliance with the International Dysphagia Diet Standardisation Initiative (IDDSI) in a Palliative Care setting

Lisa Cronin, Specialist Palliative Care Dietitian and Karen Slyne, Specialist Palliative Care Speech and Language Therapist, Milford Care Centre

Background and Aim

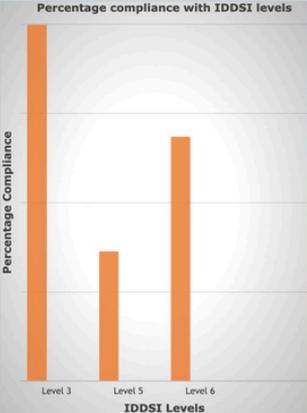
The aim of this quality improvement initiative was to audit the implementation of the IDDSI framework for individuals in a hospice setting who had been prescribed a texture-modified diet by the Speech and Language Therapist (SLT) and Registered Dietitian (RD). The process involved reviewing each texture-modified meal to ensure it was prepared accurately, thereby optimizing patient safety and reducing the risk of consuming improperly modified foods.

Methods

The observational audit was conducted over a four-week period. The Speech and Language Therapist, the Registered Dietitian, and the Head Chef completed observations on the ward pantry during the transfer of lunch meals from the hot trolley to patient trays. For each meal observed, the IDDSI level, whether the observation was completed, and details of what was noted were prospectively recorded in Excel. The results were analysed using descriptive statistics.

Results

Meal Type	No. of meals observed	No. Compliant	Percentage Compliant	Target Compliance
Level 7a (Regular Easy to Chew)	0	N/A	N/A	100%
Level 6 (Soft and Bite-sized)	19	13	68.5%	100%
Level 5 (Minced and Moist)	11	4	36.4%	100%
Level 4 (Pureed)	0	N/A	N/A	100%
Level 3 (Liquidised)	2	2	100%	100%



IDDSI Levels

Conclusion

Improving IDDSI-compliant modified meal standards through an ongoing audit process will help minimise risk and optimise quality of life for patients requiring texture-modified diets.

**References available on request.

Title: Audit of compliance with the International Dysphagia Diet Standardisation Initiative in a Palliative Care setting

Authors: Cronin, Slyne

Audits 10-22

Title: Audit of Hospital to community Discharge Forms

Authors: Azhar, Maguire, Leydon, Cleminson, Bogan, Finnerity

Audits 10-22

Title: Audit of Electronic Prescriptions to a Hospice Unit

Authors: Azhar, Finnerty, Kavanagh, Bogan

Audits 10-22

Management of Diabetes at End of Life: A Clinical Audit

Dr. David Murphy¹, Dr. Chloe Webb², Dr. Niamh Cleary¹, Dr. Faith Cranfield¹

1. St. Francis Hospice, Blanchardstown, Dublin
2. St. Francis Hospice, Raheny, Dublin

Background

The management of diabetes mellitus at the end of life involves shifting focus from the avoidance of long-term complications to solely avoiding symptomatic hypoglycaemia or hyperglycaemia and diabetic emergencies.

End of life (EoL) care focuses on maximising comfort and minimising distress, providing an appropriate level of intervention for the patient's stage of illness.

Aims and Standard

We present the results of an audit examining the management of diabetes mellitus in St. Francis Hospice (SFH), a specialist palliative care service that includes two inpatient units (IPU) in north Dublin city, one in Blanchardstown (SFHB) and one in Raheny (SFHR).

The aim was to compare current practice in the IPUs with that of the standard, the SFH Diabetes Management Guidance document.

Methodology

In the initial audit, all inpatients on a single date in SFHB were included (n=19). Patient's medical charts, medication prescriptions, and, where applicable, glucose monitoring forms were reviewed and data was recorded on an electronic audit tool.

Information was recorded on glucose monitoring, diabetic medication prescribing and deprescribing, and documentation of diabetes management. This was compared with recommendations as outlined in the guidance document.

On re-audit, the same process was used to gather information across both sites. All inpatients on a chosen date in summer 2025 in SFHB were included (n=16), and all inpatients in SFHR were included on a separate date soon after (n=16). There was one additional question added to the electronic tool, assessing if a recommendation advised after the initial audit was being followed.



Correspondence to:
davidmurphy4@beaumont.ie

Results - Cycle 1

- 9/19 patients had a monitoring form. Remaining patients did not have an indication to monitor glucose (compliance 100%).



- 0/1 patients who were identified as approaching end of life had their diabetic medications de-prescribed, and 0/1 had their monitoring discontinued.
- Documentation of decision-making surrounding diabetic management was poorly compliant in general.

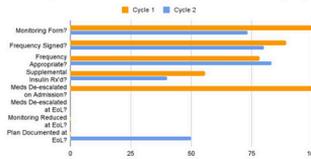
Re-audit

Interventions were carried out following the first cycle:

- Insertion of a laminated copy of the guidance document into each medication prescription folder.
- A prompt was included on monitoring form to remind prescribers to prescribe supplemental insulin.



Comparison of Cycle Results (%)



Conclusions and Action Plan

With few exceptions, compliance did not improve or disimproved despite the actions taken. This may be due to lack of education, only partial application of previous actions, or due to lack of clarity in existing guidance.

Planned interventions before re-audit include:

- Ensuring application of previous interventions.
- Review/update of existing guidance.
- Education session with incoming doctors.

Title: Management of Diabetes Mellitus at End of Life: A Clinical Audit

Authors: Murphy, Webb, Cleary, Cranfield

Audits 10-22

Title: An Audit of the Triage Process in the Palliative Medicine Department of a Tertiary Referral Centre

Authors: Kennedy, O'Connor

Audits 10-22

Audit of Family Meeting Proforma Documentation in a Specialist Palliative Care Inpatient Unit: A 2025 Re-Audit

Dr Seán Killeen, Dr María Walsh
Milford Care Centre, Castletroy, Co. Limerick



Background

- Family meetings are a core component of Specialist Palliative Care, supporting shared decision-making, communication, and care planning.
- Use of a standardised family meeting proforma promotes consistency and ensures key domains are addressed.
- Accurate documentation is essential for continuity of care and effective multidisciplinary communication.
- Regular audit supports quality improvement and maintenance of high standards of care.

Methods

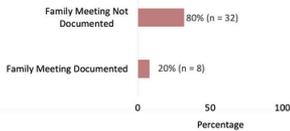
- Design:** Retrospective audit.
- Setting:** Specialist Palliative Care Inpatient Unit, Milford Care Centre.
- Sample:** Review of 40 inpatient charts (July–August 2025).
- Inclusion:** All patients admitted during the study period.
- Audit tool:** Locally developed Family Meeting Proforma audit tool.
- Data collection:** Completion of each proforma section recorded and analysed descriptively.

Aim

- To assess adherence to completion of all sections of the Family Meeting proforma by the multidisciplinary team in a Specialist Palliative Care Inpatient Unit.
- To compare findings with previous audit cycles.
- To identify areas for improvement and inform quality improvement initiatives.

Results

Figure 1: Percentage of charts audited with family meetings documented (n = 40)



Gender

Male: 62.5% (n=5), Female 37.5% (n=3)

Age

Mean 71 years (range 50 to 94 years)

Condition

62.5% (n=5) malignant conditions, 37.5% (n=3) non-malignant conditions

Figure 2: Compliance with selected family meeting documentation standards across audit cycles



Percentage compliance for key family meeting documentation standards across three audit cycles (2018, 2023, 2025).

Figure 3: Heat map of compliance with family meeting documentation standards across audit cycles

Standard	2018	2023	2025
Patient agreement to family meeting	100	100	100
Purpose of meeting recorded	100	100	100
MDT attendance recorded	100	100	100
Summary/Outcomes documented	100	90	100
Time of meeting recorded	66.7	70	87.5
Feedback provided to patient if not attending	50	100	75
Post-meeting debrief documented	88.9	100	100
Notification of SPC community services	33.3	10	0

Heat map showing percentage compliance with family meeting documentation standards across three audit cycles.

Conclusions

- Similar to previous audit cycles, 7 of 17 standards have reached 100% compliance.
- High compliance across most standards demonstrates strong multidisciplinary engagement and sustained practice improvement.
- Lower compliance in selected areas likely reflects:
 - Proforma design limitations (e.g. combined date/time entry)
 - Clinical context where community notification may not be applicable
 - Feedback to patients who do not attend meetings remains an important area for improvement to support patient autonomy.

Recommendations

- Ongoing education and communication to staff on accurately completing all areas of the family meeting proforma.
- Ensure that patients are always given feedback post family meeting if they choose not to attend.
- Amend the current proforma as follows:
 - Separate entry area for date and time may improve accurate documentation of the meeting time.
 - Change 'hospace at home' heading to 'Specialist Palliative Care Community Services'
 - Additional 'no' and 'n/a' tick boxes should be added for the 'Specialist Palliative Care Community Services' heading to improve accurate capturing of this information.
- Re-audit in 2 years

Contact Details

Seán Killeen
Email: seanjkilleen@gmail.com
Address: Milford Care Centre, Castletroy, Co. Limerick

Title: Audit of Family Meeting Proforma Documentation in a Specialist Palliative Care Inpatient Unit: A 2025 Re-Audit

Authors: Killeen, Walsh

Audits 10-22

Reaudit of Management and Documentation of Delirium in a Hospice Inpatient Unit 2024

Dr Shane Lynch, Dr Helena Myles¹
¹Palliative Medicine Consultant

Milford Care Centre

INTRODUCTION

- Delirium is highly prevalent in inpatients with palliative care needs and is associated with significant morbidity^{1,2}.
- Delirium is screened on admission using the Short Confusion Assessment Method (CAM), per NICE guidelines³.
- Previous audits (2019, 2021) identified gaps in screening, documentation and frequent benzodiazepine use in management.

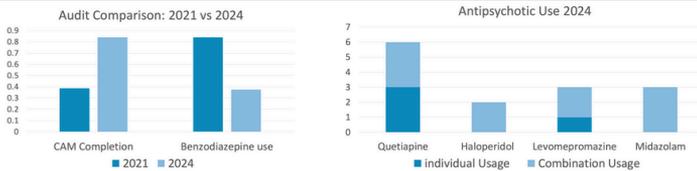
AIM

- To reassess compliance with NICE guidelines for the **screening, documentation, management, and communication**.
- Standards:** 100% completion of CAM on admission
- 100% documentation of confirmed delirium
- 100% communication with families/carers.

METHODS

A retrospective chart review of all 25 inpatients in a Hospice inpatient unit on 25/11/24 was undertaken. A novel audit tool was created based on standards derived from NICE guidelines.

RESULTS



Non-pharmacological management was used in 77.78% (n=7) of cases. **Pharmacological management** was implemented in 88.89% (n=8) of cases with confirmed delirium. An indication for the use of pharmacological management was documented in 75% (n=6) of these cases.

No healthcare records demonstrated a recompletion of short CAM on another occasion post admission. The Nursing Delirium Screening Scale – NuDESC was completed in **all cases**.

CONCLUSION

- Improvements** were seen in **delirium screening and pharmacological management**.
- Gaps** remain in **documentation and family/carers communication and post-admission screening** using short CAM.
- Benzodiazepine use has decreased, reflecting **more targeted treatment**.
- A multidisciplinary working group was established to oversee improvements. **Staff education on documentation, family communication, and non-pharmacological management** will be delivered within 6 months. A **prompt** will be added to assessment forms to ensure delirium discussions with families/carers are documented.
- The audit will be repeated in 12-18 months to assess 100% compliance, with results shared at MDT meetings.

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- National Institute for Health and Care Excellence (NICE). (2010). Delirium: Prevention, diagnosis and management (Clinical guideline [CG103]). NICE. Retrieved from <https://www.nice.org.uk/guidance/cg103>

Title: Reaudit of Management and Documentation of Delirium in a Hospice Inpatient Unit 2024

Authors: Lynch, Myles

Audits 10-22

Title: Audit of Venous Thromboembolism (VTE) prophylaxis documentation.

Authors: Healy

Audits 10-22

An Audit Of End – Of – Life – Care (EOLC) In An Irish Hospital Using The National Audit Of Care At End – Of – Life (NACEL) Case Note Review

Dr. Eithne Hudson
University of Limerick School of Medicine, Limerick
Fusheela University Hospital (FUH), Gilway
Mater Misericordiae University Hospital Dublin



Local Context

- Portlanna University Hospital (PUH): 270 – bed acute hospital.
- Observed inconsistent EOLC practices.
- 23% increase in Palliative Care referrals over 3 years.

National Context

- Aging population.
- More Irish adults living with life – limiting disease.
- New National Adult Palliative Care Policy.
- National annual audit likely once policy implemented; no current auditing measure.

Aims

- To examine the degree of concordance with EOLC standards captured in the NACEL Case Note Review within FUH.
- Assess use of an amended version of the NACEL Case Note Review in the Republic of Ireland.

Standards

- NICE Guideline 31;
- NICE Quality Standards 13 & 144;
- 'One Chance to Get it Right: Improving People's Experience of Care in the Last Few Days and Hours of Life' (LACDP).

Methodology

Data Specification & Collection

- Audit (2023): deaths March – June 2022 reviewed.
- Re – audit (2025): deaths October 2024 – January 2025 reviewed.
- 50 retrospective whole chart reviews per audit / re – audit.

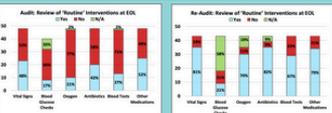
Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none"> • Adult deaths: 18+ years. • Category One Deaths: It was recognised that the patient may die imminently. • Category Two Deaths: The patient was not expected to die. 	<ul style="list-style-type: none"> • 'Sudden Deaths': <ul style="list-style-type: none"> • ED deaths. • Deaths < 4 hours post admission. • Deaths due to a sudden catastrophic event, with full escalation plan in place. • Suicides & Maternal deaths.

Results

Communication



Care Planning



Comfort



• Areas of greatest non – concordance were: communication, continuation of 'routine' interventions at EOL & hydration / nutrition.

- Recommendations & Action Plan**
- Presentation of audit results at Grand Rounds to raise MDT awareness.
 - Implementation of a '3C' (Communication, Care Planning & Comfort) focused approach for all patients flagged as dying during daily safety huddles.
 - Targeted MDT education.
 - Recruitment & education of Palliative Care Nurse Champions.
 - Re – audit in 12 – 18 months' time.

Re – Audit

• Re – audit demonstrated improvement in all areas.

- Recommendations**
- Continued focused staff education by the Specialist Palliative Care Service & support of Palliative Care Nurse Champions.
 - Annual re-audit (as per the NACEL Case Note Review guidance) is recommended, however this may be unrealistic given service constraints.

Conclusions

- Although the action plan appeared effective, the audit was undertaken by a single reviewer, potentially biasing results.
- Findings were limited by the detail & legibility of paper documentation. Difficulty accessing charts resulted in delayed re – audit.
- Re – audit captured Winter deaths, versus Spring / Summer deaths in the initial audit. Over – representation of a more co – morbid, incapacitated & unconscious patient cohort may have occurred, limiting comparability.
- This is the first use of the NACEL Case Note Review in the Republic of Ireland. An amended NACEL Case Note Review could be used to audit concordance with the new National Adult Palliative Care Policy, rather than de – novo tool development. Repetition of the audit in an alternative setting would help to support this assertion.

1. All Irish Audits of Palliative Care (APC) 2012. Report on the Department of Health Public Consultation for the National Case Note Review. A Report by All Ireland Audits of Palliative Care (APC) 2012. Report on the Department of Health Public Consultation for the National Case Note Review. Dublin: 2012.
2. Guidelines for the Care of Dying Patients 2016. (The Director of Health Services, Planning Director's Department of Care in the Last Few Hours of Life). London: United Kingdom: 2016.
3. National Adult Palliative Care Policy 2024. (The Director of Health Services, Planning Director's Department of Care in the Last Few Hours of Life). London: United Kingdom: 2024.
4. National Adult Palliative Care Policy 2024. (The Director of Health Services, Planning Director's Department of Care in the Last Few Hours of Life). London: United Kingdom: 2024.
5. National Adult Palliative Care Policy 2024. (The Director of Health Services, Planning Director's Department of Care in the Last Few Hours of Life). London: United Kingdom: 2024.
6. NICE Quality Standard 13. Care of Dying Adults in the Last Few Hours of Life. 2015.
7. NICE Quality Standard 144. Care of Dying Adults in the Last Few Hours of Life. 2015.
8. NICE Quality Standard 144. Care of Dying Adults in the Last Few Hours of Life. 2015.

Title: An Audit of EOL Care in an Irish Hospital, Using the NACEL Case Note Review.

Authors: Hudson

Audits 10-22

Title: An audit of assigned patient category and AKPS in an acute hospital specialist palliative care service

Authors: Kelly, Beatty, O Riordan

Audits 10-22

Title: Audit of Antimicrobial Use at End of Life in Acute Hospital Setting

Authors: Donnellan, Doherty, O Gorman

Audits 10-22

Improving Palliative Care Outcomes Collaborative (PCOC) Score Completion on Admissions to an IPU

Dr Cian O'Leary, Dr Patricia Sheahan, Dr Margaret Clifford
Kerry Specialist Palliative Care Services
University Hospital Kerry



Background

Kerry Specialist Palliative Care Services (KSPCS) Inpatient Palliative Care Unit (IPU) has seen growing numbers of referrals for admission in recent years

IPU beds are a limited resource, and there is pressure to triage admissions effectively. Prospective admissions are triaged daily via review of admission proformas

Palliative Care Outcomes Collaborative (PCOC) scores are a focal point of our admission proformas and assist in effective triage by highlighting at risk patients

Aim

Assess PCOC Score completion for admission referrals to our IPU

Standard

Our existing admission proforma was used as our standard

Methodology

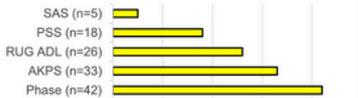
Admission proformas for all patients admitted to IPU for July - September 2024 were reviewed.

The 5 parameter of PCOC scoring were recorded as completed or absent – Palliative Care Phase, Australia-modified Karnofsky Performance Status (AKPS), RUG Activities of Daily Living (RUG ADL), Problem Severity Score (PSS), and Symptom Assessment Scale (SAS)

Proforma's with only one parameter filled were noted as partially complete.

Conclusions, Recommendations and Action Plan

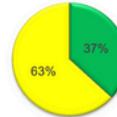
PCOC Score Parameter Completion on Admission Referral Proformas to IPU



16.7% (n=7) of logged scores were partially completed

Conclusions, Recommendations and Action Plan (contd)

PCOC Score Compliance (Initial) n=114 Admissions



■ Any PCOC Score Logged (n=42)
■ No PCOC Score Logged (n=72)

Conclusion:

- Poor overall compliance with PCOC Score Completion

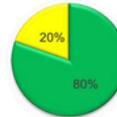
Action plan implemented:

- NCHD education session regarding PCOC scores/our admissions process
- Registrar allocated to assess admission proformas daily for PCOC score completion, seeking missing information

Results and Reaudit of Implemented Recommendations

Admissions from February - April 2025 were reaudited post action plan

PCOC Score Compliance (Post Action Plan) n=107 Admissions



■ Any PCOC Score Logged (n=86)
■ No PCOC Score Logged (n=21)

Rate of partially filled scores remained stable (n=14, 16%). Palliative Care Phase remained the most logged parameter (100%, n=86)

Successful implementation of Action Plan with over twice the compliance with PCOC score completion on reaudit (36.8% vs 80%). Going forward the implemented action plan is recommended as our standard of care for admissions listing.

Title: Improving Palliative Care Outcomes Collaborative (PCOC) Score Completion on Admissions to an IPU

Authors: O Leary, Sheahan, Clifford

Audits 10-22

Audit of Treatment Escalation Plans in a Community Specialist Palliative Care Service

Mauro Casey, Siobhan Burke, Eimear Hallissey, Margaret Clifford

Kerry Specialist Palliative Care Services (KSPCS), University Hospital Kerry



BACKGROUND

Palliative patients should be given an opportunity for Advance Care planning, and have a documented Treatment Escalation Plan (TEP) that is accessible by all involved in their care, particularly out of hours. KSPCS has an out of hours telephone advice service that is answered by nurses in the palliative inpatient unit who have access to the Community Specialist Palliative Care Team's electronic notes.

Aims and Objectives

To audit the documentation of treatment escalation plans in Kerry community specialist palliative care service's (CSPCT) electronic notes, accessed out of hours by the SPC telephone advice service.

Audit Findings

An audit was conducted against the following standards: All patients should have a clearly documented TEP containing resuscitation status, whether for acute hospital admission, for treatment of reversible conditions outside hospital or comfort measures only. If there is no agreed TEP the reasons should be clearly documented.

The notes of all patients on the CSPCT caseload on 30th November 2023 were reviewed. Of 188 patients, 144 (77%) had a TEP documented. However, none of them contained all the key components outlined in the standards. Those without a documented treatment escalation plan had no documentation about why it was not discussed and agreed.

Re-Audit

Following education sessions, we introduced a drop down box for documentation of TEP's, with the possibility of removing content control for those who required further detail outside of the standard wording. Formal discussion of TEP's at the weekly MDT meeting was introduced.

The CSPCT caseload on 9th October 2025 was reviewed. Of 198 patients, 147 (74%) had a documented treatment escalation plan which was slightly lower than the original audit. However, 140 TEP's (95%) were clearly worded with reference to all the key components. Of the 51 patients with no TEP, the reason for not discussing was documented in 45 (88%). The table below shows the contents of the TEP's. The TEP's that were not clearly worded are fitted into the category that appears to fit best based on the wording used.

Treatment Escalation Plan Details	Number (%)
For CPR and Active Management	20 (10%)
DNACPR but transfer to acute hospital for treatment	38 (19%)
DNACPR treat reversible conditions at home or in palliative inpatient unit	46 (23%)
DNACPR for comfort measures only	33 (17%)
Patient / family wishes for active treatment	1 (0.5%)
Patient / family wish to make decision at the time	8 (4%)
Documented as not having been discussed	45 (23%)
Nothing documented re TEP	7 (3.5%)

CONCLUSIONS AND RECOMMENDATIONS

Our findings suggest that prompts / drop down menu increases clarity of Treatment Escalation Plans.

Our audit only looked at the presence and clarity of documentation of TEP's. We cannot conclude that all of them were up to date and consistent with the patient's clinical condition.

CONCLUSION

Embedding review of TEP's into MDT meeting discussions and collaboration with primary care colleagues will be essential in ensuring that all patients have a clearly documented TEP appropriate to the patient's current clinical status.

Examining the appropriateness of the documented TEP relative to the patient's clinical condition and documented wishes and goals may be helpful in future audits.

Acknowledgements

Paula Murphy and Fiona Dillon, Administrative Officers, Kerry Specialist Palliative Care Services

Title: Audit of Treatment Escalation Plans in a Community Specialist Palliative Care Service

Authors: Casey, Burke, Hallissey, Clifford

QI Projects 23-41

Title: ‘Uniting for Safety’: A Collaborative Approach to Managing Falls in Inpatient Palliative Care”

Authors: Batty, Walsh

QI Projects 23-41

BREATHE BETTER PROGRAMME

Breathlessness beyond the patient: addressing breathlessness and the psychosocial needs of carers as a collaborative intervention in Specialist Palliative Care.

Caroline Quinn (Principal Medical Social Worker), Maria Álvarez (Senior Physiotherapist), Galway Hospice.



BACKGROUND

In March 2025, Galway Hospice launched the **Breathe Better Programme (BBP)**, a physiotherapy-led breathlessness management intervention for people with advanced illness. Breathlessness is a highly distressing and disabling symptom, causing significant anxiety for patients and **impacting greatly on informal carers**.

BBP was designed collaboratively by Physiotherapy and Medical Social Work (MSW), embedding **carer support from the outset**. This dual-focus approach reflects a holistic model of specialist palliative care, recognising the essential role of carers in symptom management and the wellbeing of patients.

The programme consisted of ten sessions over five weeks, combining education and exercise (which lasted approximately 30 minutes each). Carers were invited to attend education sessions with patients and participated in **four peer support sessions facilitated by MSW**.

AIMS

PATIENTS

- Improve symptom control
- Maximise function
- Better quality of life
- Reduce anxiety
- Increase confidence

CARERS

- Emotional support
- Reduce isolation
- Improve carers' confidence to assist patients with symptom management
- Understanding of dyspnoea in advanced illness

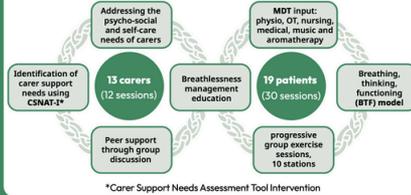
METHODOLOGY

PATIENTS SELECTION: SAS dyspnoea ≥ 2 , AKPFS ≥ 50 , stable phase of illness. Max of 10 participants, min of 4.

CARERS were invited to attend the education component of the BBP and specific carer support sessions with the MSW.

OUTCOME MEASURES USED:

- 30 Seconds Sit-to-Stand (STS)
- Grip Strength (Hand Held Dynamometer)
- EQ-5D-5L (BBP 1 and 2)
- Canadian Occupational Performance Measure COPM (BBP3)
- Modified Borg Dyspnoea Scale
- London Chest Activity Of Daily Living Scale LCADL (BBP 1)
- Patient Experience: Focus Groups



FINDINGS

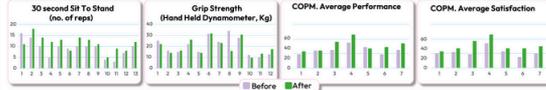
- BBP was a **timely and effective intervention**, optimising existing hospice resources.
- Enabled patients and families to **build rapport with hospice services** and address fears and misconceptions.
- **High participation and interest**, with some attendance challenges due to illness unpredictability.

PATIENTS:

- Sample size not statistically significant; however **marked improvements** observed in performance and satisfaction measures (30s STS, Grip Strength, COPM).
- Standardised dyspnoea and QoL measures (LCADL, EQ-5D-5L) were less effective in capturing patient experience; **focus groups** provided richer qualitative feedback.

CARERS:

- **Peer support:** Shared experiences reduced isolation and fostered belonging.
- **Role recognition:** Increased confidence, validation, and awareness of the carer role.
- **Emotional wellbeing:** Improved coping, resilience, and attention to self-care.
- **Capacity to support:** Greater understanding, communication, and confidence in supporting patients and seeking further help.



FEEDBACK FROM CARERS

- “Everyone is fighting the same battle and to know you are not on your own”
- “I have started to do things for myself again as my world was getting very small”
- “We have started to enjoy the things we used to do together again and before illness took over”
- “I felt valued as a carer and getting to meet other carers, and somewhere to talk about your worries and fears”
- “The Breathe Better Programme was brilliant and worked at both levels- for me as carer and dad... would highly recommend it”

FEEDBACK FROM PATIENTS

- “I’ll go because I might learn something more to my benefit – and I feel I have”
- “The course has been very good to me in two ways: the physical benefit and the emotional benefit”
- “It’s not about preparing to die – it’s preparing to live until you die”
- “It was fab just to meet people in the same position as you are – you think you’re the only one, but you’re not”
- “Each time I come down, I feel better for it”

CONSIDERATIONS FOR FUTURE PRACTICE

1. BBP demonstrated **physical, emotional, and social benefits** for patients and carers, addressing gaps in breathlessness support and aligning with the **National Adult Palliative Care Policy (2024)**: ‘Right Care, Right Place, Right Time, Right People’.
2. **Peer support** will inform future service development and resource allocation, supporting understanding of hospice services and building trust as illness progresses.
3. Group size should be carefully planned to optimise participation and peer support, given illness unpredictability.
4. **Multidisciplinary collaboration** is essential to programme planning and delivery.

References

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3. Dept of Health National Adult Palliative Care Policy 2024
4. Grande G, Irving G. CSNAT-4: Carer Support Needs Assessment Tool-Interim. University of Manchester, 2025

Acknowledgement:

Patients and carers involved in the BBP who participated in the evaluation.

Title: Breathlessness beyond the patient: addressing breathlessness and the psychosocial needs of carers as a collaborative intervention in specialist palliative care.

Authors: Alvarez, Quinn

QI Projects 23-41



Defining “Category 1” – A Service Evaluation of Acute Hospital Based Specialist Palliative Care Activity

Dr. Anna Hayes, Dr. Eithne Hudson, Dr. John Drought,
Dr. Ryan Fagan, Dr. Aoibheann Conneely, Dr. Norma O’Leary



Background & Rationale

- Acute hospitals are the most common place of death in Ireland (National End of Life Survey, 2023).
- 62% of cancer patients had a hospital-based palliative care encounter in the year before death (Kelly et al., 2020).
- Greater socio-economic deprivation is associated with increased likelihood of dying in hospital (McFarlane & Carduff, 2016).
- No national key performance indicators currently exist for hospital-based Specialist Palliative Care (SPC).

St James’s Hospital (SJH) SPC Service:

- Serves a population with high levels of socio-economic deprivation.
- Experiencing rising referral volumes & increasing waiting times.



A Structured Triage System Based on Clinical Need was Introduced:

- Category 1: daily review.
- Category 2: 2-3 reviews per week.
- Category 3: weekly review.

Results

Referrals:

- August 2024: 147 referrals; Category 1: 36% (n=42).
- January 2025: 184 referrals; Category 1: 33% (n=45).

Clinical Need:

- 74 - 80% had uncontrolled physical symptoms.
- 29 - 35% had significant psychosocial distress.
- 62 - 76% required subcutaneous infusions.

Care Trajectory & Outcomes:

- Over 75% were receiving End of Life Care (EOLC).
- The majority died during the same hospital admission, highlighting the acute hospital as a key site of EOLC.

Timeliness of Review:

- Nearly half were reviewed on the day of referral. Mean time to SPC review was 1.49 days.

Referral Accuracy:

- Prognosis was frequently over-estimated by referring clinicians.
- In August, 12% were referred with a prognosis of “days,” yet 48% died within one week.

Reason for Referral:	August 2024 (n=42)	January 2025 (n=45)
- Symptom Control (SC)	32 (76%)	38 (85%)
- End of Life Care (EOLC)	8 (19%)	5 (11%)
- Consideration for Hospice	2 (5%)	4 (9%)
Category 1 Triage List Review	13 (31%)	23 (52%)
EOLC Under SPC	35 (83%)	4 (9%)
Continuous Subcutaneous Infusion (CSI)	32 (76%)	38 (85%)
Uncontrolled Physical Symptoms	32 (76%)	33 (73%)
Psychosocial Distress	17 (40%)	14 (31%)
Outcomes:		
- Discharged from Hospital	-	17
- Died in Hospital	25	32
- Discharged to Hospice for SC	1	0
- Discharged to Hospice for EOLC	8	4
- Discharged Home for EOLC	0	1
- Improved & Discharged Home	8	8

The majority of referrals had cancer; 86% in August & 69% in January. Cancer patients were more likely to be known to SPC. No non-cancer related cases were known to SPC.

Increased numbers of referrals in January likely represented a seasonal surge in presentations due to respiratory illness. This is supported by an increase in numbers of respiratory, non-malignant referrals in tandem with increased referrals for EOLC.

Aims & Objectives

- Examine characteristics & outcomes of Category 1 patients.
- Review information captured on referral forms.
- Assess the utility of categorisation for clinical efficiency & effectiveness.
- Inform quality improvement of referral & triage processes.

Conclusions

- The Category 1 triage system identifies patients with the highest need, ensuring timely review despite increasing referrals.
- Structured categorisation supports clinical efficiency & provides insight into SPC workload.
- Prognostic inaccuracy at referral highlights the need for improved guidance & clinician education.
- Ongoing evaluations will monitor seasonal variation, care trajectories & the role of prognosis, supporting continuous refinement of referral & triage processes.

Methodology

- Approval was granted via the Hospital Quality, Safety & Improvement Department.
- A retrospective chart review was conducted of all patients referred during August 2024 & January 2025. Duplicate, rejected or outpatient referrals were excluded.

Title: Defining “Category 1” – A service evaluation of acute hospital-based specialist palliative care activity.

Authors: Hayes, Hudson, Drought, Fagan, O Leary

QI Projects 23-41

Title: Exploring Factors Delaying Triage in an Outpatient Specialist Palliative Care Service: A Quality Improvement Initiative

Authors: Hayes, Keane, O Reilly, McAleer, Doherty

QI Projects 23-41

First Encounters in Palliative Care

A Quality Improvement Approach to Undergraduate Medical Teaching

Authors
Dr Rita Neves
Dr Conor White



Affiliations
Tallaght University Hospital
Trinity College Dublin

Contact
ana.ritaneves@tuh.ie

Background and Rationale

Clinical placements are a cornerstone of undergraduate medical education, yet their structure and impact vary. A scoping review of clinical placement models found that structured placements with defined objectives, supervision, and reflection improve student satisfaction, confidence, and learning compared with unstructured shadowing (1). This is especially relevant in palliative care, where undergraduate exposure is limited and many graduates report feeling unprepared to support patients with life-limiting illnesses (2). In our service, third-year medical students previously attended a one-week palliative care placement with no standardized structure or formal evaluation, which risked missed opportunities for early professional development in palliative care principles.

Aims and Objectives

- Develop and implement a structured, evidence-based learning framework for third-year medical students on their first palliative care placement.
- Improve student satisfaction, confidence, and knowledge in palliative care.
- Introduce and emphasize the multidisciplinary team (MDT) approach and holistic assessment in an acute hospital setting.

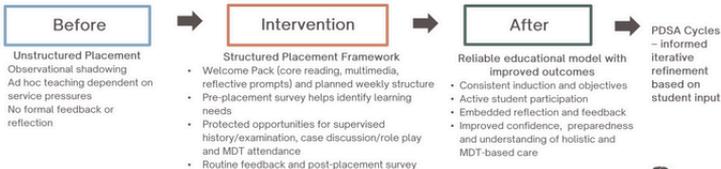
Methodology

Design: Education Quality Improvement Project using iterative development and pre- and post placement evaluation

Participants and Setting: Third-year medical students undertaking a compulsory one-week placement in an Acute Hospital Palliative Care Setting. One student per placement, 3 placements per Term (3 months). N=9 to date

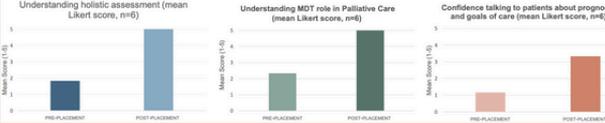
Measures: Student-reported confidence, understanding and preparedness (Likert scale); Process measures including supervision, feedback, opportunities for active participation; attendance at MDT and qualitative free-text feedback.

Analysis: Descriptive analysis of pre- and post-placement survey responses and thematic analysis of qualitative comments to inform iterative refinement



Results

Preliminary findings from first implementation phase (n=9 students; n=6 matched surveys)
Process measures: 100% of respondents strongly agreed that they received good quality teaching and that the placement met their learning needs.
Qualitative feedback recurring themes: seeing holistic care delivered in practice, exposure to MDT in acute palliative care
"Seeing communication with patients and families at such difficult time was very helpful for future work"



Conclusion, Sustainability and Next Steps

This QIP addressed a previously unstructured undergraduate palliative care placement by introducing a structured, evidence-informed framework. Early findings demonstrate improved student confidence and understanding of holistic and MDT-based palliative care, transforming passive shadowing into active, supervised learning. The intervention is low-cost and has been integrated into routine placement induction through a standardised structure, Welcome Pack, and feedback process. Ongoing PDCA cycles with continued data collection will inform further refinement. Planned next steps include exploration of longer-term impact on clinical practice and preparedness.

Contribution to Palliative Care Practice

This project supports earlier and more meaningful integration of palliative care principles into undergraduate medical education. By improving preparedness, communication confidence, and understanding of holistic, multidisciplinary care, it contributes to workforce development and promotes the wider embedding of palliative care across hospital practice. The structured framework offers a scalable model for acute palliative care services to standardise student placements and strengthen future palliative care delivery.

References: Neves CN et al. Clinical placement models for undergraduate students. BMC Med Educ. 2023; 23(1):1-6. Neves CN et al. Newly qualified doctors and end-of-life care preparedness. Med Educ. 2021.

Title: First Encounters in Palliative Care: A Quality Improvement Approach to Undergraduate Medical Teaching

Authors: Neves, White

QI Projects 23-41

Developing Updated Guidelines for Diabetes Management at End of Life - A Quality Improvement Project

Dr. David Murphy¹, Prof. Regina McQuillan^{2,3}, Prof. Karen Ryan^{1,4}, Dr. Faith Cranfield¹

1. St. Francis Hospice, Blanchardstown, Dublin
2. St. Francis Hospice, Raheny, Dublin
3. Beaumont Hospital, Dublin
4. Mater Misericordiae University Hospital, Dublin



Background/Problem Identified

An audit was carried out to compare current practice to the existing guidance on diabetes management at end of life in St. Francis Hospice (SFH). There were significant shortcomings evident. Out of 18 standard, only 3 had >80% compliance.

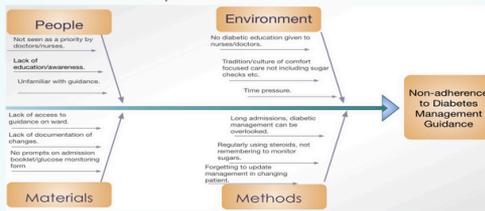
On discussing the possible reasons for this, several were identified. A major factor, it was felt, was that there was room for improvement in existing guidance in terms of clarity and comprehensiveness.

Aims

- To demonstrate an improvement in the management of diabetes in patients in SFH (compliance >90% with audit in 6 months).
- To develop updated guidance for clinical staff on the management of diabetes in palliative patients in SFH.

Methodology

- Stakeholders were identified these included SFH consultants and NCHDs, nurse managers and staff nurses, pharmacists, patients and families.
- Fishbone analysis undertaken to identify possible causes, then PDSA cycle was undertaken.



PDSA

Change Idea	Plan	Do	Study	Act
Updating diabetes guidance	<ul style="list-style-type: none"> • Literature review. • Expert opinion from endocrinology colleagues 	<ul style="list-style-type: none"> • Trial new guidance in patient folders. 	<ul style="list-style-type: none"> • Guidance too long for folders, impractical and removed. • NCHDs unable to locate guidance when needed. 	<ul style="list-style-type: none"> • Short version created for folders. • QR code for electronic access. • Dedicated place for paper copy on ward.
Education	<ul style="list-style-type: none"> • Informal discussions with NCHDs and nursing staff about attitudes/awareness. 	<ul style="list-style-type: none"> • Emails circulated to all staff. • Education session for NCHDs. 	<ul style="list-style-type: none"> • Good engagement from NCHDs after session. • Nursing staff less aware of new guidance. 	<ul style="list-style-type: none"> • Schedule education session as part of induction for NCHDs. • Involve nurse managers in regular education/awareness raising during handovers for nursing staff.

Results

- There was good feedback regarding the comprehensiveness of the guidance, however it became too long to keep in patient folders and were difficult to locate.
- There was good engagement from NCHDs after the education session.
- Overall there was a mixed response on re-audit, with improvements in some areas and static results in others.
- Nursing staff were variably aware of the new guidance.

Conclusions

- Some improvements have been made, but not to the target. Adaptations have been made, and ongoing PDSA cycles will aim to demonstrate ongoing quality improvement.
- If effectiveness is demonstrated, adapted versions of this guidance may be rolled out to hospitals in the local hospital network.

Correspondence to: davidmurphy4@beaumont.ie

Title: Developing Updated Guidelines for Diabetes Management at End of Life - A Quality Improvement Project

Authors: Murphy, Ryan, McQuillan, Cranfield

QI Projects 23-41

Evaluation of a facilitated carer support group in a specialist palliative outpatient and day service.

Joan Boyle MSW, Anne Casey MSW, Emer Honan CNS, Martina O'Dowd MSN,
Vanessa Scanlon MSW



St. Francis Hospice

Background

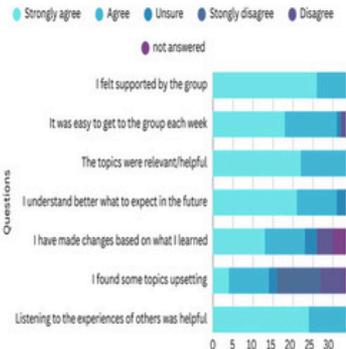
Our Outpatient and Day Service (OPDS) has run a carer support group since 2015. The group is facilitated by a medical social worker and clinical nurse specialist and consists of four weekly sessions. Participants are family carers of community-based patients in receipt of care from our hospice, and who are identified as likely to benefit from attending a peer support group with interdisciplinary facilitation. To ensure those attending found it of benefit, and to inform further service development, an evaluation of the experience of participants over a two-year period was conducted.

Methodology

Participants were invited to provide feedback on completion of the final session, with 34 participants completing this. A Likert scale was used to evaluate responses. Some participants also provided feedback by indicating descriptions which best aligned with their experience of attending. Given the anonymized nature of included data, ethical approval was not sought. Data was compiled in relation to each question and results collated, providing comprehensive feedback.

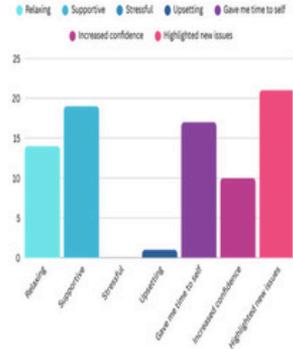
Outcomes

Legend: Strongly agree (light blue), Agree (medium blue), Unsure (dark blue), Strongly disagree (purple), Disagree (dark purple), not answered (grey)



Question	Strongly agree	Agree	Unsure	Strongly disagree	Disagree	not answered
I felt supported by the group	25	10	0	0	0	0
It was easy to get to the group each week	20	10	0	0	0	0
The topics were relevant/helpful	20	10	0	0	0	0
I understand better what to expect in the future	20	10	0	0	0	0
I have made changes based on what I learned	15	10	0	0	5	0
I found some topics upsetting	10	10	0	0	10	0
Listening to the experiences of others was helpful	25	10	0	0	0	0

Legend: Relaxing (light blue), Supportive (medium blue), Stressful (dark blue), Upsetting (purple), Gave me time to self (dark purple), Increased confidence (pink), Highlighted new issues (red)



Theme	Frequency
Relaxing	14
Supportive	19
Stressful	1
Upsetting	17
Gave me time to self	10
Increased confidence	21
Highlighted new issues	21

Conclusion

Findings suggest that 100% of participants felt supported by the group, found topics relevant and felt that listening to the experiences of others was helpful. A large majority found it easy to access the group and indicated a better understanding of what to expect in the future. Areas for further evaluation were identified. 42% participants found some topics upsetting, and for some new issues not previously considered were highlighted as they arose during discussion.

Implications for Practice

Carers within the palliative care context can experience uncertainty, isolation and anticipatory grief. This evaluation confirms that they benefit from supports that sustain them in their caring role while maintaining meaningful relationships with their loved one during illness and into bereavement. Results relating to some topics being upsetting and to the identifying of new issues as they arose during discussion have informed a decision to offer a follow up session to participants who require this on completion of the program.

Title: Evaluation of a facilitated carer support group in a specialist palliative outpatient and day service.

Authors: Honan, Scanlon, Boyle, Casey, O Dowd

QI Projects 23-41

Qualitative Analysis of a Palliative Care Advanced Nurse Practitioner delivered service for Residential Care Facilities

Dr. Mary McCarthy, Tina Bolger RANP, Brid O'Connor RANP, Dr. Margaret Clifford, Dr. Patricia Sheahan

Background

Studies have suggested that support provided by a Specialist Palliative Care (SPC) Nurse to staff of residential care facilities (RCFs) caring for patients with palliative care needs can improve patient outcomes and staff satisfaction in their role. Two palliative care ANPs were employed to provide this support in Kerry.



Contributions to Palliative Care

This qualitative analysis of the Palliative Care ANP service in RCFs highlights its positive impact on the continuity of care, communication with patients, their families and among healthcare professionals along with its impact on improving knowledge and confidence of staff providing generalist palliative care in the



UNIVERSITY HOSPITAL KERRY

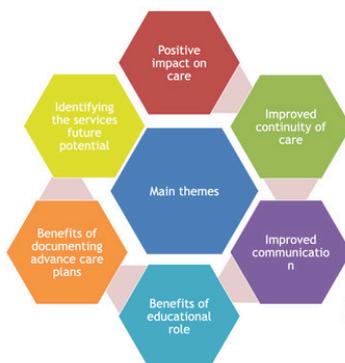
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Aim

To qualitatively evaluate the Palliative Care ANP service provided to residential care facilities, identifying its impact on healthcare professionals caring for the residents.

Methods

Six semi-structured interviews were undertaken to obtain qualitative data. Those interviewed included the Directors of Nursing of a privately funded nursing home and of a charity funded nursing home, the CNM2 of a Community Hospital, along with three GPs who acted as the GP lead for specific RCFs. Thematic analysis of these interviews was performed.



Originality of the project

Providing a dedicated palliative care ANP service to RCFs is a novel approach to providing specialist palliative care to this specific cohort of patients in Ireland

Conclusion

A palliative care ANP service for residential care facilities is an effective approach in enabling healthcare professionals to address the palliative care needs of residents in care facilities with confidence and competence in a holistic, collaborative and compassionate manner.



Title: Qualitative Analysis of a Palliative Care Advanced Nurse Practitioner delivered service for Residential Care Facilities

Authors: McCarthy, Bolger, O Connor, Clifford, Sheahan

QI Projects 23-41

Enhancing Nursing Confidence and Competence in End of Life Care in Surgical Wards

Naoise Brennan, Clinical Nurse Manager 2
Private 3, Surgical Inpatients, St James's Hospital, Dublin

A good death in hospital is possible, our challenge is to make it happen.

Introduction

- Health care professionals have the vital responsibility of ensuring that end-of-life care (EOLC) is a meaningful and compassionate experience for patients, their families, and even for themselves as caregivers.
- There were 97 deaths in Surgical Inpatients wards in 2024 and 116 in 2025.
- Staff Nurses and Healthcare Attendants often report a lack of confidence in supporting dying patients and their families. This can contribute to challenges such as miscommunication, reduced delivery of holistic care, and increased emotional strain for staff and patients.
- This highlights the need for a structured programme to enhance staff competence and confidence and promote compassionate EOLC.

Aim & Objectives

This quality improvement project aims to improve confidence and competence in delivering EOLC among Staff Nurses and Healthcare Attendants in Surgical Inpatients

- Develop and deliver the Surgical Inpatients Final Journeys Programme, aiming to improve end-of-life care by promoting a culture of awareness and enabling personal empowerment.
- Develop a draft competency framework for EOLC.
- Foster a supportive & trusting environment where staff feel equipped and empowered to provide exemplary end-of-life care, improving outcomes for patients, families and within the care team.

Methods

Planning

Attended Final Journey Two-Day Facilitator Course with Irish Hospice Foundation

Training Need Analysis

Prepare the Draft competency

Implementation

Run the Final Journeys study day & workshop

Evaluation

Review Feedback & Make Improvements

Phase 1: Study day, Phase 2: workshop

Design the programme

Liaise with Key Stakeholders

Results: Phase 1

Draft Nursing competency for End of Life Care ✓

How would you rate the overall experience of attending this study day?

Day 1 – End of Life Care Study day for Nursing Staff ✓

"I can contribute to a safer, better, end of life care in my hospital"

100% of participants AGREED!

Feedback

- I am more confident when communicating with patients and family members regarding end-of-life
- I am more mindful of the emotional impact that performing last offices can have on my colleagues, I now ensure that they take a break if needed
- I plan to take this knowledge back to the ward to share with my co-workers, I am more comfortable around the idea of death and dying, I understand more about what I can do to make a difference
- I have more confidence in discussing death with families as an HCA, not bringing work home with me and ensuring that I look after myself and my colleagues post-EOLC

Conclusion

- The Surgical Inpatients In Patient Final Journey Programme has enhanced end-of-life care by building confidence and competence in nurses and HCAs, fostering effective communication and compassionate support for patients and their families.
- The programme advances palliative care by fostering a supportive & trusting environment where staff feel empowered to provide exemplary EOLC, improving outcomes for patients, families and within the care team.
- Staff have also recognised the importance of prioritising their own self-care while caring for the dying patient.

Future Plans

- Run phase 2 of the Programme – End of Life Skills Workshop
- Roll out End of Life Care Competency
- Surgical Inpatients End of Life Care Champions to train as Final Journey Facilitators and run workshop stations

Surgical Inpatients Final Journey Participants

26 Participants: 2024

Title: Enhancing Nursing Confidence and Competence in End-of-Life Care in Surgical Wards

Authors: Brennan

QI Projects 23-41

The Development of Algorithms To Manage Laryngectomy-Associated Emergencies within Specialist Palliative Care. A Medical and Speech and Language Therapy Collaboration

Dr Kyle Taheny¹, Claire Parkes², Valerie Flood³, Dr Des McMahon³



¹ Specialist Registrar, North West Hospital, Sligo.
² Speech & Language Therapy Department, Our Lady's Hospice and Care Services.
³ Consultant in Palliative Medicine, Our Lady's Hospice and Care Services.

Background

- Patients with a laryngectomy may present with life-threatening emergencies, including bleeding, respiratory distress, and dislodgement of the tracheoesophageal voice prosthesis.
- Existing emergency algorithms are designed for hospital or community use and do not reflect the unique requirements of a specialist palliative care unit (SPCU), where ceilings of care and person-centred decision-making are central.
- This gap can leave SPC staff underprepared to respond safely and appropriately.

Aims & Objectives

- This project aimed to develop SPCU-specific emergency management algorithms for laryngectomy-associated complications.
- Objectives were to integrate ceilings of care into decision-making frameworks and to provide accessible, clear, and context-appropriate tools to support safe, consistent emergency responses.

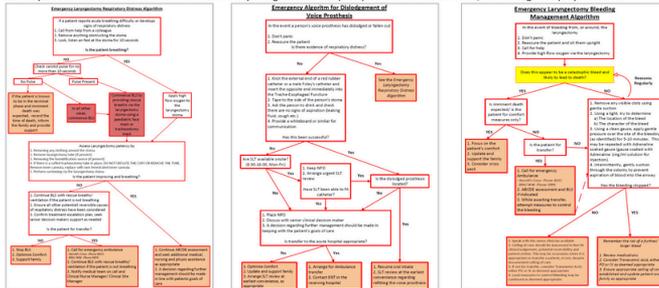
Methodology

- A non-consultant hospital doctor and speech and language therapist co-designed three emergency management algorithms for laryngectomy-associated complications: (1) respiratory distress, (2) voice prosthesis dislodgement, and (3) bleeding.
- Stakeholder analysis, review of existing guidelines and local expert opinion were utilised in the algorithm development.
- These were produced in concise, stepwise formats and made available as posters, digital resources, and folder inserts across SPC wards.
- Educational sessions introduced the tools and their intended use.



Results

- Algorithms were designed for rapid reference in high-pressure scenarios and were accessible in multiple formats.
- They explicitly incorporated ceilings of care, tailored escalation pathways, and interdisciplinary communication. Simplicity and clarity were prioritised to suit staff with varied experience.
- Preliminary feedback indicated that the tools effectively bridged acute hospital protocols and SPC needs, enhancing staff preparedness.



Conclusion

- These are, to our knowledge, the first algorithms embedding ceilings of care into the emergency management of laryngectomy patients within SPC.
- This quality improvement initiative aligns emergency management with palliative care values, ensuring responses are both safe and appropriate.
- This project forms part of the first stage in a knowledge, skills and confidence process. The availability of clear, context-specific algorithms strengthens consistency and preparedness while providing a replicable model for managing other rare emergencies in SPC.

Contact:
Claire Parkes
Speech and Language Therapy Manager,
Our Lady's Hospice, Harold's Cross,
Dublin 6W
E: csparkes@olh.ie
W: <https://olh.ie>
Company no: 352404
RCN: 20001827
CHY: 1144

Further information:
Please contact us if you would
like to obtain a copy of the
algorithms or would like to
discuss further

Title: The Development of Algorithms To Manage Laryngectomy-Associated Emergencies within Specialist Palliative Care. A Medical and Speech and Language Therapy Collaboration

Authors: Taheny, Parkes, Flood, McMahon

QI Projects 23-41

Regular Capillary Blood Glucose Monitoring for Non-Diabetic Hospice Inpatients Prescribed Corticosteroids: Quality Improvement Project

Dr. Helena Myles, Katie Irwin, Dr Mary McCarthy, Dr Sarah Rutledge, Emma Stodart.

Background

- Short-term use of corticosteroids is associated with insulin resistance and risk of steroid-induced diabetes mellitus
- A recent audit in Milford Hospice demonstrated a lack of regular capillary blood glucose (CBG) monitoring in hospice inpatient prescribed corticosteroids
- These results prompted this quality improvement (QI) project to ensure safe, timely, effective inpatient screening for development of steroid-induced diabetes mellitus

SMART Aim

S	Specific
M	Measurable
A	Achievable
R	Relevant
T	Time-bound

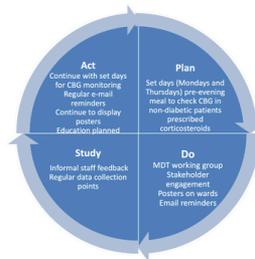
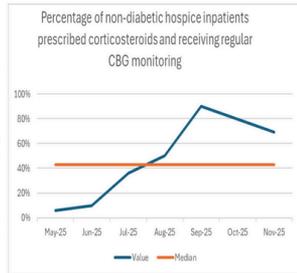
- To increase regular CBG monitoring for non-diabetic hospice inpatients from a baseline of 6% to 75% over 6 months

Methods

- Formation of a multidisciplinary (MDT) working group
 - Medicine (Palliative Medicine Consultant and Specialist Registrar)
 - Clinical Nurse Manager
 - Pharmacist
- Set days (Mondays and Thursdays) chosen to check pre-evening meal CBG in an effort to increase regular monitoring. A similar initiative has been successfully undertaken in a UK hospice.
- Engagement with stakeholders to maximise the impact of the proposed change
- Two PDSA (plan, do, study, act) cycles were undertaken
- Data regarding frequency of CBG monitoring were collected monthly and presented on a run chart

Results

- Regular CBG monitoring in non-diabetic hospice inpatients prescribed corticosteroids improved from 6% to 69% from May to November 2025
- Feedback demonstrated staff satisfaction and a desire for further education
- Education sessions are planned
- Members of the working group provide ongoing motivation to ensure sustainability



Conclusion

- This intervention is transferable to other hospice inpatient units to promote a standardised approach to monitoring for steroid-induced diabetes mellitus in this patient cohort
- Regular CBG monitoring has increased significantly following application of QI tools and concepts



Reference
McCullough, C. (2018). 151 Monitoring Corticosteroids: An improvement project in a Scottish Specialist Palliative Care Unit. *BMJ Supportive and Palliative Care* 8(Suppl 1):A1-79.



Title: Regular Capillary Blood Glucose Monitoring for Non-Diabetic Hospice Inpatients Prescribed Corticosteroids: Quality Improvement Project

Authors: Myles, Irwin, McCarthy, Rutledge, Stodart

QI Projects 23-41

'Developing a Palliative Nutrition Algorithm to Guide Assessment, Support and Referral'



Melanie Nugent, Tracy Haylett, Joanne Clarke, Ann McSorley, Lisa Cronin, Didi Zwarte, Tracey Stewart, Helena McCloskey, Sarah Naughton, Fionnuala Hamilton, Sarah Donnelly, Aisling O'Grady, Janine Briggs, Marie Hannon

Background

Nutrition is a core component of holistic palliative care, but access to specialist dietitians is inconsistent across Ireland. Non-dietitian healthcare professionals are frequently required to address nutrition related concerns, leading to variation in practice and uncertainty. Evidence highlights the need for structured tools to guide safe, evidence-based nutritional decision-making in palliative care.

Aim

To design and pilot an algorithm enabling non-dietitians or non-specialist palliative care dietitians to:

- Screen palliative care patients for nutrition related symptoms
- Grade severity using a validated symptom assessment scale
- Provide appropriate first-line advice
- Identify clear thresholds for referral to specialist and non-specialist dietitians

Method

An all-Ireland group of specialist palliative care dietitians developed a screening and decision-support algorithm through evidence review, expert consensus and stakeholder input. The tool integrates the Symptom Assessment Scale (0-10), triaging responses into: 1) manageable locally, 2) referral to non-specialist dietitian or 3) referral to specialist palliative care dietitian. Pilot implementation is about to commence.



Results

Pilot implementation is about to commence and results will be presented at the conference. Anticipated benefits include increased confidence of non-dietitian staff in addressing nutrition, more consistent practice across teams and clearer thresholds for referral to specialist palliative care dietitians

Originality of Project

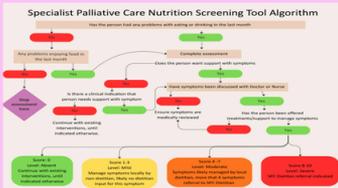
To our knowledge no country has implemented a national algorithm specifically designed to support non-dietitians in palliative nutrition decision-making. This project represents a novel, cross-border quality improvement initiative

Contribution to Palliative Care

The algorithm strengthens capacity across the workforce, standardises care and ensures timely referral. It also empowers non-dietitians to provide safe, person-centred nutritional support.

Conclusion

An all-Ireland specialist palliative care dietitian algorithm offers a practical, scalable approach to improving nutritional care. Wider implementation and formal evaluation are planned to assess impact on patient outcomes.



References
Dugan T. (2017) 'Managing the nutritional needs of palliative care patients' British Journal of Nursing, vol.28, no.21.

For further information please contact
Tracy Haylett - Tracy.Haylett@sestrust.hscni.net or
Lisa Cronin - L.Cronin@milfordcarecentre.ie
Chairs of the AIHPC Dietitian Community of Practice



Title: Developing a Palliative Nutrition Algorithm to Guide Assessment, Support and Referral

Authors: Nugent, Haylett, Clarke, McSorley, Cronin, Stewart, McCloskey, Zwarte, Naughton, Hamilton, Donnelly, O Grady, Briggs, Hannon

QI Projects 23-41

Title: Renal Palliative Supportive Care Pathway Development

Authors: Paffrath, Moodley, McEvoy, McAnallen, Griffin, Brady

QI Projects 23-41

Title: A multidisciplinary Quality Improvement Initiative on Oral Symptoms in inpatients with advanced cancer

Authors: Kelly, McDonnell, Igoe, Loughnane, Fahy, Pounder, Gantley, Beatty, O Riordan

QI Projects 23-41

The Development of Algorithms for Tracheostomy-Associated Emergencies in a Specialist Palliative Care Unit. A Multidisciplinary Approach

Dr Kyle Taheny¹, Claire Parkes², Dr Mary McCarthy³, Sharon Cranny⁴, Dr Des McMahon⁵



¹ Specialist Registrar, North West Hospice, Sligo.
² Speech & Language Therapy Manager, Our Lady's Hospice and Care Services.
³ Specialist Registrar, Millford Care Centre, Limerick.
⁴ CNM2 in Practice Development, Our Lady's Hospice and Care Services.
⁵ Consultant in Palliative Medicine, Our Lady's Hospice and Care Services.

Background

- With increasingly medically complex individuals accessing specialist palliative care (SPC), patients with tracheostomies are often admitted to hospice for end-of-life care, symptom control or respite.
- Ceilings of care can vary depending on the individual's will and preference and on the stage of the person's illness.
- Within our organisation, staff lacked timely, appropriate guidance for tracheostomy-associated emergencies, such as respiratory distress, accidental decannulation, and bleeding.
- Existing national algorithms were unsuitable for the hospice's nuanced, person-centred approach.

Aims & Objectives

- The aim of this Quality Improvement Project was to develop algorithms to aid in the management of acute emergencies associated with tracheostomies, within a specialist palliative care context.
- The objectives were to create simple, easily accessible, focused, management algorithms that incorporated hospice specific detail, such as ceiling of care, staff expertise and resources available in the event of an emergency.

Methodology

- A multidisciplinary team (MDT) of doctors, speech and language therapists, and nurses developed algorithms for emergencies specific to the ceilings of care for persons with a tracheostomy in a hospice setting.
- Stakeholder analysis was undertaken, with national and local guidelines used in conjunction with local expert opinion to develop bespoke algorithms.



Results

- The MDT designed three algorithms for tracheostomy-associated emergencies.
- These were approved by the local policies and procedures committee and are readily available and in use.
- Education, awareness campaigns and measures of its use are ongoing.

Conclusion

- To our knowledge, these are the first algorithms designed for patients specifically in a hospice setting for the management of tracheostomy-associated emergencies.
- This project forms phase one in an MDT approach to ensure individuals with tracheostomies receive care appropriate to their needs and ceilings of care, with subsequent phases planned to audit its use and collaborate with other organisations at a national level.
- It is projected that the MDT will feel more confident in recognising and appropriately managing tracheostomy associated emergencies.

Contact:
Claire Parkes
Speech and Language Therapy Manager,
Our Lady's Hospice, Harold's Cross,
Dublin 6W
E: cparkes@olh.ie
W: <https://olh.ie>
Company no: 352404
RCN: 20001827
CHIY: 1144

Further information:
Please contact us if you would like to obtain a copy of the algorithms or would like to discuss further

Title: The Development of Algorithms for Tracheostomy-Associated Emergencies in a Specialist Palliative Care Unit. A Multidisciplinary Approach

Authors: Taheny, Parkes, McCarthy, Cranny, McMahon

QI Projects 23-41

Intravenous infusions for symptom management in Specialist Palliative Care: Multidisciplinary team Quality Improvement Project

Kieran Skehan¹, Darren Walsh¹, James Cullinane², Suzanne Ryan^{1,2}

¹Department of Palliative Medicine, University Hospital Waterford, Waterford, East Palliative care



Background and Context for Change

Local context

- The south-east palliative care centre (hospice) was commissioned in 2021 and is co-located on an acute hospital site.
- The local palliative care Committee is a multidisciplinary body that meets regularly to provide oversight and governance of medicines management and use within the unit.
- There is a limited number of staff with experience in the management of intravenous route consideration of intravenous administration of hours. However, the intravenous route was not utilised due to the absence of an agreed policy, thereby highlighting the need for the development of formal guidance.

Problem Statement

- The current administration of medications is the most frequently used route to palliative care units for symptom management in the terminal phase.
- There is a need to ensure medicines management in the terminal phase is safely managed to achieve adequate symptom control. Although the use of the intravenous route for symptom management in terminal care has been reported, it has not yet been formalised.
- Frequent clinical incidents can result in reduced staff familiarity and confidence.

Why is this important?

- Ensures effective symptom management when standard routes fail.
- Ensures medicines management in the terminal phase is safely managed to ensure consistent patient quality and safety.

Aim statement

- Develop a policy, approved by the local Medicines Management Committee, to support the use of intravenous infusions for symptom management in the terminal phase in the acute hospital.

Methods

- UK QI methodology was used.
- For calculations were identified, information was used in a framework.
- Process mapping and fishbone diagrams were utilised for a deeper understanding of the current practice.
- SMART objectives were identified and measured.
- Following the Model for Improvement framework, Plan-Do-Study-Act (PDSA) cycles were used to test and refine the intervention.
- Information was gathered using an environmental scan consisting of staff surveys, national guidance, and a review of intravenous medication use within the acute hospital site.
- Information was gathered using a formal methodology, was presented to staff to create an evidence base.

Figure 1. Fish bone Diagram

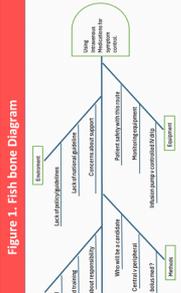


Figure 2. Driver Diagram

Change of Ideas

Primary Driver

- Primary Driver: Patients
- Secondary Driver: Change of Ideas

Aim

- Primary Driver: Patients
- Secondary Driver: Change of Ideas

Figure 3. PDSA Cycles

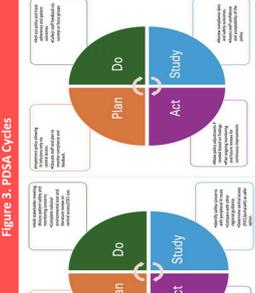


Table of objectives

Objective	Implementation	Measure
Formulate a Quality Improvement team with agreed terms of reference August 25.	Include nursing, medical and pharmacy representation.	Meeting to agree terms of reference by August 2025.
Gather local, national and international information.	Conduct literature review, stakeholder meetings and surveys.	Literature review summary and survey results by September 2025.
Draft a Medication for symptom management in the terminal phase policy by November 2025.	Collate all information, incorporate relevant elements of UHW policy.	Policy Drafted by November for December committee meeting agenda.

Survey Results

- Nursing (n = 18): 100% not confident with continuous intravenous infusion; 70% aware of policy; 100% confident with the route and ethical issues.
- Medical (n = 5): 60% confident; none aware of policy; main concern was how to administer intravenous infusions.

Scoping Literature Review

- Identified 10 articles relevant to the topic.
- Consistent with other hospice networks, nationally identified some case reports and guidance on administering continuous intravenous infusions via central venous access devices (CVADs) in local hospital policy.

Conclusions

- The project employed a structured quality improvement approach to develop a continuous intravenous infusion policy for symptom management in the terminal phase in an acute hospital route where patients are unable to tolerate oral or subcutaneous medications.
- Initial plan for approval intravenous infusion route was not met due to lack of staff resources and governance.
- The project highlights the value of an agreed and standardised policy in supporting local clinical governance, and governance supporting continuous quality improvement and maintaining clinical governance, promoting consistency of practice, enhancing staff confidence, and ensuring patient safety.

Title: Intravenous infusions for symptom management in Specialist Palliative Care: Multidisciplinary team Quality Improvement Project

Authors: Skehan, Walsh, Cullinane, Ryan

QI Projects 23-41

Transitions of Care – Implementation of a county-wide Specialist Palliative Care Single First Assessment document

Marymount

Dr Hannah O'Brien,^{1,2} Dr Sinead Leonard,¹ Dr Orfhlaith McCarthy,¹ Ger O'Farrell,¹ Abina Moynihan,¹ Jill Mc Carthy,¹ Alice Fitzgerald,² Susan Hilliard,² Sheila Kelly,¹ Paulina Szymanska,¹ Dr Adrian Yan,² Dr Jessica Lee,¹ Dr Aoife Lowney^{1,2}

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



Introduction

- The Cork Specialist Palliative Care (SPC) service serves 5 public hospitals, a 44 bed SPC Inpatient Unit (IPU) and Community Palliative Care and Outpatient Department with an approximate 650 patient caseload.
- Cork is the largest county in the state with a community catchment area spanning 2500km² including islands.
- A significant barrier to streamlining of patient care is the provision of care across many different healthcare providers operating in silos.



Aim

- The purpose of the Transitions of Care Quality Improvement Project (QIP), which sits within the Front Door QIP, is to streamline and improve coordination of palliative care across all providers in the county.

Objectives

- Collaborate with the service providers to develop a *Single First Assessment (SFA)* document
- Implement the SFA at all points of entry to the SPC service
- Facilitate virtual transition of the SFA
- Compare first assessments before and after implementation of the SFA

Results

- Time and Motion Cycle 2 included 57 measurements (e.g. administration, nursing, medical) across 4 sites.
- In one acute setting 24 minutes reduction in time was observed in administration and nursing time in Cycle 2 where SFA was available.
- SPC IPU admission time decreased by up to 39 minutes where SFA was available on admission from Cycle 1 to Cycle 2.
- Where SFA was not available on admission to IPU time also decreased by up to 70 minutes in Cycle 2.
- Community assessment times reduced between 19 minutes with SFA and 29 minutes without SFA in Cycle 2 in comparison to Cycle 1.
- Administration time required decreased in one acute hospital setting by 4 minutes between Cycles 1 and 2 and, by 11 minutes in Cycle 2 with SFA versus no SFA. In comparison administration time increased in IPU and CPC both with and without SFA in Cycle 2.
- Increasing number of SFAs received by hospital settings where patients known e.g. to CPC. Where SFA previously completed by the same person this decreased time required for patient re-referral.

Conclusions

- The SFA reduces duplication, ensures pertinent clinical information safety transitions settings and lessens patient burden.
- A further Time and Motion study will assess further incorporation into patient care and potential areas for improvement.
- Exploring patient and family experiences will allow a 360-intervention insight.
- With the advent of Trakcare® patient management software under the Community Connect project this project may be replicated country-wide.
- The limitations of the iCare software system may be addressed with the bespoke Trakcare® software solution for Specialist Palliative Care.

Methodology

- The Plan Do Study Act (PDSA) framework was implemented.
- A Lean principles approach was adopted.
- Data Protection Impact Assessment (DPIA) conducted with data protection officer.
- A patient information leaflet was developed.
- A cross-site multidisciplinary working group included SPC representatives from acute hospitals, SPC IPU and community teams.
- Site-specific process maps summarised administrative, nursing and medical first assessment components.
- Consensus was reached for a 'Single First Assessment' (SFA) document.
- Expert facilitator training sessions supported roll-out in November 2024.
- A centralised GDPR compliant iCare platform was approved.
- A cross-site Time and Motion study was conducted, pre and post-SFA implementation, with stakeholder feedback.
- Healthcare staff experiences were explored through informal feedback and with dissemination of staff experience survey.

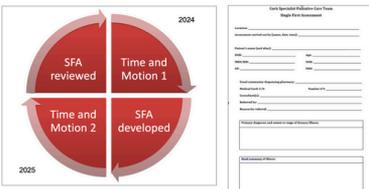


Figure 1. Single First Assessment PDSA cycle

Acknowledgements

Thank you to everyone in the Cork Palliative Care service including colleagues who represented CUH, MUH, CPC and SPC Inpatient Unit. Thank you to all disciplines including Nursing, Medical, Pharmacy, OT, Physio, Dietetics, SALT, Pastoral Care, ADONs, ONMs and administration colleagues particularly Paulina Szymanska.

Title: Transitions of Care – Implementation of a county-wide Specialist Palliative Care (SPC) Single First Assessment (SFA) document.

Authors: O'Brien, Lee, Fitzgerald, Hilliard, McCarthy, Moynihan, McCarthy, Leonard, Lowney

QI Projects 23-41

Title: Implementation of the Age Friendly Health Systems 4Ms Framework in a Specialist Palliative Care Inpatient Unit – A Quality Improvement Project

Authors: O'Brien, Broe, Daly, Dukelow, James, Foley, Dennehy

Research



Empowering NCHDs: An Interdisciplinary Quality Improvement Project in Anticipatory Prescribing

Dr Alexandra Boyd Crotty, Dr Faisal Zeb, Dr Brian Creedon, Frances Moore, Jane Shore, Edvina Lyng
St Luke's General Hospital, Kildare
Contact: alyboycrotty@gmail.com

Background & Rationale →

Anticipatory prescribing of subcutaneous PRN medications is **essential** for symptom control in the last days of life.

National guidance recommends that four core medications are prescribed in advance, ideally **24-48 hours before death**.

Local review identified that prescribing was generally accurate, but often **delayed** and commonly initiated **only after specialist palliative care review**, increasing the risk of unmanaged symptoms, particularly out of hours.

Methodology →

Measures:

Retrospective chart review of expected deaths on selected medical ward.

- Four-drug anticipatory PRN bundle completeness.
- Dose accuracy.
- Timing of prescribing (≥ 24 h and ≥ 48 h before death).
- Initiation before vs after palliative care review.



Intervention:

- Baseline findings → development of anticipatory prescribing guideline.
- MDT co-produced: pharmacy, nursing, palliative care, medical staff.
- Disseminated at ward level and via MEG app, introduced at teaching/grand rounds/circulated in sitilo groups.

Analysis:

- Baseline data (May-July 2025, n=17) compared with re-audit data (Sept-Oct 2025, n=14) using descriptive statistics.
- No unintended adverse consequences were identified.

Originality of Project:

This project progressed from audit to quality improvement by translating findings into a concise, NCHD-focused prescribing guideline. MDT co-production prioritised frontline usability and enables transferability across inpatient settings.

Contribution to Palliative Care →

This intervention supports timely symptom control, reduces out-of-hours delays, and enables non-specialist clinicians to prescribe safely without waiting for specialist review, optimising palliative care resources.

Aim →

To improve the **timeliness and completeness** of anticipatory prescribing for adult inpatients at end of life.

Objectives →

- Evaluate local anticipatory prescribing practice against national standards.
- Assess completeness, dosing accuracy and timeliness of prescribing.
- Identify reliance on palliative care review prior to initiation.
- Implement and evaluate intervention supporting NCHDs to prescribe proactively.

Figure 1: Completeness of four-drug anticipatory PRN prescribing.

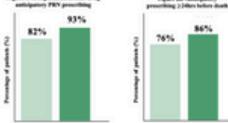


Figure 2a: Anticipatory prescribing <24hrs before death.

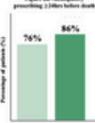


Figure 2b: Anticipatory prescribing >48hrs before death.

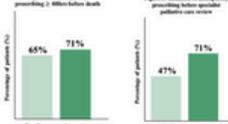
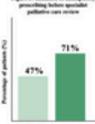


Figure 3: Initiation of anticipatory prescribing before specialist palliative care review.



Results →

- Completeness and timeliness of anticipatory prescribing improved following the intervention (Figures 1, 2a, 2b).
- Prescribing prior to specialist palliative care review increased substantially (Figure 3).
- Improvements associated with guideline accessibility and MDT engagement.
- Positive feedback from staff especially junior colleagues.



Figure 4: Quality Improvement Project Plan

Conclusions and Next Steps...

- NCHD-focused guidance improved anticipatory prescribing without compromising safety.
- Sustainability supported by MDT co-production and ward-level integration.
- Next steps: spread to additional wards including surgical wards and embed in NCHD induction.

Standards/References →

- HSE National Clinical Programme for Palliative Care Model of Care (2019): Recommends anticipatory prescribing of core medications for patients recognised as dying.
- HSE Pharmaceutical Management of Common Symptoms in Palliative Care (2023): outlines appropriate starting doses for common end-of-life symptoms.
- Galway University Hospitals "Optimal Care at End of Life in Hospital" Guidance Booklet (2024), pp. 28-30 specifies four core PRN 5-C meds with recommended doses and general advice.
- NICE NG31: Care of Dying Adults in Last Days of Life (2015): endorses anticipatory prescribing to ensure rapid access to symptom control.

Title: Empowering NCHDs: An Interdisciplinary QIP in Anticipatory Prescribing at End of Life

Authors: Boyd, Crotty, Creedon, Moore, Shore

Research

Title: Enhancing Palliative Care Integration of Healthcare Services in the West of Ireland; A collaborative approach using Project ECHO and a specialist palliative care in-person hospice education programme for nursing homes.

Authors: Butler

Research

Title: Developing a Reflective Practice Programme to Support Oncology and Palliative Care staff with Patient Death

Authors: Kelly

Research

Palliative day care - an update based on an international interdisciplinary secondary data analysis



Ulster University
Faculty of Life and Health Sciences



Introduction

Palliative day care is a model of care designed for patients living at home with Day Care facilities offering access to clinical, psychological and social care along with providing respite to care partners.

The model is not new: the first day care service opened in Sheffield, in 1959.

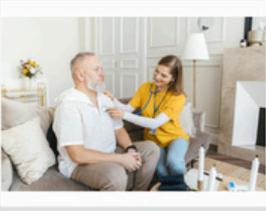
Many other countries, including Ireland, Canada, and many others have been inspired to establish their own version.

Aim and Methods

Aim: To examine the distinctive features of day care services that have endured, as well as the changes they have undergone, to identify avenues for development of these programs.

Design: Thematic meta-synthesis of two qualitative studies data sets.

Analysis: Combined analytic expansion approach to identify similarities and distinctions between the services identified in the two original studies.



Results –

Results were drawn from group and individual interviews with 19 participants in Canada, including 13 professionals and 6 managers across six services, and 35 participants across Ulster, Scotland and Northern England, including 16 professionals and 18 managers from three-day care services.

The administrative structure of services, the adoption of a palliative care philosophy and the multidisciplinary nature of the professional and volunteer teams are the components of the programs that have endured.

However, patient characteristics, the care model and institutionalization are relatively new features and are constantly evolving.

Conclusions

As palliative care continues to innovate to adapt to the needs of their patients, the evolution of their components is desirable.

However, pressure to demonstrate the relevance of their services to justify financial resources could, while ensuring their sustainability, deprive them of the values and practices that are, in reality, their most valuable assets.

Authors

Dr Felicity Hasson, Prof George Kernohan,
Ulster University,
Gabrielle Leblanc-Huard, Dr Gabrielle Fortin,
Laval University, Quebec, Canada.

Title: Palliative Day Care- an update based on an international interdisciplinary secondary data analysis

Authors: Hasson, Kernohan, Leblanc-Huard, Fortin

Research

Title: An Exploration of the spiritual needs of children with life limiting conditions- A Qualitative Evidence Synthesis.

Authors: Conroy

Research

Antibiotic Use in Patients Approaching End of Life Retrospective Review in a Tertiary Irish Hospital

Eva Jones¹, Fergal Howley², Ciara Anderson², Ryan Fagan³, Sam Grennan², Bettina Korn⁴, Liam Townsend^{2,5}, Ciaran Bannan^{2,5}, Aoibheann Conneely^{1,5,6}

1. Department of Palliative Medicine, St James's Hospital, Dublin
2. GU/ID Department, St James's Hospital, Dublin
3. Acute Medical Unit, St James's Hospital, Dublin
4. Department of Nursing, St James's Hospital, Dublin
5. Department of Clinical Medicine, Trinity College Dublin
6. Our Lady's Hospice and Care Services, Dublin



Contact: evajones00@gmail.com

Introduction

Antibiotic prescribing at end of life is common in hospitals, with frequent use up to hours before death. Perceived benefits of antibiotic use must be balanced against the risk of potential patient harm and the wider implications of increasing antimicrobial resistance. There is limited evidence for use of antibiotics in this cohort.

Objectives

1. To describe patterns of antimicrobial use among inpatients who died in a Model 4 Irish hospital.
2. To investigate factors associated with antimicrobial use in the final four weeks of life.
3. To assess rates of microbiological sampling during this time

Methods

1. **Study setting and participants:** retrospective review of antimicrobial use among inpatients during their last 4 weeks of life in a Model 4 Irish hospital in January – June 2023. This period was chosen to mitigate seasonal bias in prescribing habits.
2. **Clinical covariates:** Data collected included antimicrobial agents and duration of therapy, microbiological sampling, infection services input, palliative care services input, patient demographics, frailty scores, and markers of inflammation.
3. **Statistical analysis:** Descriptive statistics. Univariate analysis and multivariable linear regression were used to assess factors associated with antimicrobial-free time before death.

Results

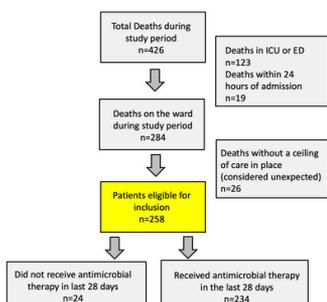


Figure 1. Patient enrollment diagram illustrating deaths during the study period, patients meeting exclusion criteria, and eligible patients who received antimicrobial therapy. Abbreviations: ED, emergency department; ICU, intensive care unit.

Results

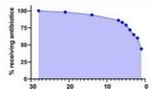


Figure 2: Percentage of patients receiving antimicrobials in the days preceding death

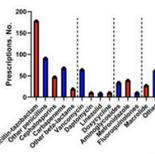


Figure 3: Antimicrobial agents prescribed in the final 4 weeks of life. Dashed lines group antimicrobials into broad classes: penicillins, cephalosporins, and carbapenems; gram positive agents; gram negative and anaerobic agents; atypical and other agents.

Patient Factors	Spearman's Rho (ρ)	P Value	Hazard Ratio (95% CI)	P Value	
Age	0.04	.56	0.51 (0.34-0.68)	<.0001	
Sex	0.09	.89	0.99 (0.94-0.99)	<.0001	
Comorbidity Count	0.03	.70	Infection service	0.86 (0.58-1.26)	.45
Clinical Frailty score	-0.03	.68	Input	1.23 (0.87-1.68)	.25
Admission Factors			Colonisation		
Palliative Care consult	.31	<.0001			
Admission team	-0.06	.39			
Length of stay	0.45	<.0001			
Laboratory Factors					
WBC at admission	-0.07	.41			
WBC peak	-0.06	.34			
CRP at admission	-0.08	.32			
CRP peak	-0.11	.16			
Any positive culture	-0.08	.37			
MIRDO colonisation	-0.11	.08			

Table 2. Predictors of Antimicrobial-Free Time Before Death

Table 1. Factors Associated With Discontinuation of Antimicrobials

258 patients were included, with 91% receiving antimicrobials during the study period (Fig. 1). Only 36% had a presumed infection at the time of admission. Antimicrobial use was characterized by broad-spectrum agents. (Fig. 2), did not correlate with culture results, and had a median duration (interquartile range) of 10.5 (5–18) days. Palliative care consultation ($P = .004$) and longer length of stay ($P < .0001$) were associated with a longer antimicrobial-free interval before death (Table 2.). Within the antimicrobial cohort, 26% developed acute kidney injury. Cessation of antimicrobial therapy often occurred late; 40% of patients receiving antimicrobial therapy within 24 hours of death (Fig 2.).

Conclusion

There was a high burden of antimicrobial use in patients nearing the end of life, characterized by broad-spectrum, empiric therapy, often continued until hours before death. We recommend expansion of antimicrobial surveillance and collaboration between infection and palliative care services to optimize and rationalize antimicrobial prescribing near end of life.

Read our published paper



Title: Review of antimicrobial use in the last four weeks of life in tertiary Irish Hospital

Authors: Jones, Howley, Fagan, Anderson, Grennan, Korn, Townsend, Bannan, Conneely

Research

Butterfly Project: Supporting children and young adults affected by bereavement in SJH ICU

General Intensive Care Unit, St. James's Hospital.
Natalia Fernández-Montenegro López (SN), Shauna Gollogly (CF), Shona Keogh (CNM2)
in collaboration with the End-of-Life Champion Group.



INTRODUCTION

Bereavement in the Intensive Care (ICU) presents a difficult time for both families and healthcare professionals, posing a challenge when children are affected. The Butterfly Project is a quality improvement initiative first developed 10 years ago as a result of a recognised need for appropriate information to be available for bereaved children and families.

Unlike traditional bereavement support which often focuses on adult relatives, the butterfly Project integrates child centered resources into critical care practice. This represents an innovative nurse-led approach to addressing the often-overlooked bereavement needs of children.

AIM

Develop a standardised approach in offering resources to help guide and support bereaved children and their families/guardian.

METHOD

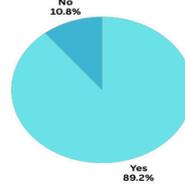
A range of age-appropriate material is provided to bereaved children or young adults, as well as a booklet which is a supportive guide for the Parent/Guardian and includes information on bereavement. Packs are color coded by age making it simple for staff to choose the appropriate bag for the bereaved child.



A bookmark is provided with each pack

Colouring books and pencils are available for children

Do you think the Butterfly Resources are useful?



RESULTS

A survey carried out in the ICU and completed by 35 nurses showed 100% awareness of the project.

However, only half of the staff believe the packs facilitated open communication indicating a need for further education to build confidence.

CONCLUSION

The survey findings demonstrated that while the majority of staff find the resources beneficial and easy to use, there remains a need for more education for the pack as a way of facilitating open communication.

REFERENCES

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The Irish Childhood Bereavement Network (2021) Irish Childhood Bereavement Network. Available at: <https://www.childhoodbereavement.ie/> (Accessed: 18 May 2025).



Title: Butterfly Project: Supporting children and young adults affected by bereavement in SJH ICU.

Authors: Gollogly

Research

PHYSICIANS' PERSPECTIVES OF INITIATING SPECIALIST PALLIATIVE CARE REFERRAL

Paula Ward¹, Registered Advanced Nurse Practitioner, Dr. Louise Daly², Associate Professor
¹ Midland Regional Hospital Tullamore, ² School of Nursing & Midwifery, Trinity College Dublin

1 Introduction

- Specialist palliative care relies on physician referral.
- Physicians often act as "gatekeepers" to these services.
- Despite evidence of benefit, referrals are frequently delayed.
- Understanding physician perspectives is essential to improve access.

Aim of Systematic Review

To synthesise qualitative evidence on physicians' experiences of initiating Specialist Palliative Care referrals

2 Methods

Design Systematic review using **JBI meta-aggregation** to synthesise qualitative evidence into practice-relevant findings.

Databases Comprehensive searches conducted in MEDLINE, CINAHL, and PsycINFO.

Timeframe Studies published from **database inception to April 2024**.

Inclusion Qualitative studies exploring **physicians' experiences of initiating palliative care referrals**.

Analysis Standardised **JBI critical appraisal** and **data extraction**, with meta-aggregation conducted using **JBI SUMARI**.

Ethics Ethical approval not required as the review included **published studies only**.



Fig. 1 JBI Meta Aggregation Methodology

3 Results

Included Studies: 28 qualitative studies involving **539 physicians** across multiple specialities. Most studies were from the **USA (46%)**, followed by **Australia** and the **UK**, with additional representation from France, Germany, Ghana, Belgium and Japan.

Synthesis Overview: From **243 extracted findings**, **11 categories** were developed and synthesised into **four key findings**.



Figure 2: Meta aggregation results

Key Meta-aggregation Findings:

1. **Referral Process:** Variability in timing, processes, and operational factors influencing when and how referrals occur.
2. **Language & Culture:** Communication challenges and cultural sensitivities shaping referral discussions.
3. **Interpersonal Relationships:** Influence of physician-patient relationships, family dynamics, and interdisciplinary collaboration.
4. **Education:** Identified need for training to address misconceptions and improve confidence in initiating referrals.



Figure 3: Synthesised findings .

4 Discussion

- Referral initiation is influenced by **operational, relational, cultural, and educational factors**.
- **Unclear referral timing and processes**, along with misconceptions about palliative care, contribute to delays.
- **Communication challenges and family dynamics** shape physicians' referral decisions. Physicians act as key **gatekeepers**, with **interdisciplinary collaboration** facilitating earlier referral.
- **Clear referral pathways and targeted education** support timely, patient-centred access to specialist palliative care.

Strength & Limitations

Strength: Rigorous JBI meta-aggregation ensured trustworthiness

Limitation: English-only and mostly U.S. studies may limit generalisability.

5 Conclusion

- To support earlier and more effective palliative care referrals strengthening **interdisciplinary collaboration**, improving **education**, and adopting **culturally sensitive approaches** are essential
- Physicians face **interconnected challenges** when initiating palliative care referrals.

6 References

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Contact: paula.ward1@hse.ie

Title: Physicians' Perspectives on Initiating Specialist Palliative Care Referrals: A Systematic Review of Qualitative Evidence

Authors: Ward, Daly

Research

Experiences and perspectives of occupational therapists working with palliative patients at end of life in Ireland

Sarah Delaney, Clinical Specialist OT, BSc, MSc

St. Francis Hospice

Background

Occupational therapists (OTs) play an integral role in the care of palliative patients at the end of life. Evidence addressing OT practice in this context remains limited, restricting the profession's ability to realise its full potential and effectiveness (Waehtrens et al., 2023). Furthermore, little is known about the scope of practice or the experiences of Irish OTs working in palliative care at end of life.

Aim

To explore the perceptions and experiences of OT's role with palliative patients at end of life in Ireland

Methods

44 OTs completed a 15-item online cross-sectional survey, consisting of mixed and opened questions. Thematic analysis and descriptive statistics were completed to analyse the data.

Hospice (15) Community (20) Hospital (8) Residential (1)

Results

There was a noticeable difference between the scope of practice and frequency of interventions provided to palliative patients at end of life, between OT's working in specialised palliative care (SPC) and generalist palliative care.

Research Themes

Barriers to practice

- Limited resources
- Lack of understanding of the OT role at end of life
- Complexity of needs at end of life
- Limited co-ordination of patient care between SPC and generalist services

59% identified that the OT profession was not utilised to its full potential at end of life.

47.7% Strongly agreed their work with palliative patients was emotionally challenging at end of life.

16% reported that staff shortages limited their ability to provide a fully holistic service at end of life.

Conclusion

The finding emphasises the importance of promoting the scope of OT practice at end of life to encourage greater allocation of staffing. Additionally, it highlights the need for further education and training for OT's working at end of life to enhance their confidence and skill set.

Implications for practice

- Enhancing collaboration between specialist palliative and generalist services would greatly improve patient care and support service development in palliative care.
- Developing strong clinical networks of support in specialist palliative services would be beneficial for generalist services.

Waehtrens et al., (2023). International consensus on occupational therapy interventions for people with palliative care needs: A European Association for Palliative Care Group Concept Mapping study. *Palliative Medicine*, 37(9), 1389-1401. doi:

Title: Experiences and perspectives of occupational therapist working with palliative patients at end of life in Ireland

Authors: Delaney

Oral symptom assessment in older patients with frailty using the Oral Symptom Assessment Scale

Prof Andrew Davies^{1,2,3}, Prof Roman Romero-Ortuno^{1,4,5}, Dr Amanda Lavan¹, Dr Niamh Cleary^{1,3}

¹ Trinity College Dublin, ² University College Dublin, ³ Our Lady's Hospice (Dublin), ⁴ Global Brain Health Institute (Dublin), ⁵ St James' Hospital (Dublin)



BACKGROUND

Frailty is a common condition/syndrome in older patients. A recent meta-analysis of frailty prevalence in European countries [1] identified an estimated pooled prevalence across all healthcare settings of 18% (95% CI 15–21%; 68 datasets; 13 932 individuals; $p < 0.003$). Frailty is regarded as a “state of vulnerability” [2] in which even a minor stressor may result in adverse health outcomes [3] independent of chronological age [4]. Oral problems in older patients may also be associated with increased morbidity and mortality [5]. Oral symptoms like dry mouth are common in older patients. There is a paucity of research examining oral symptoms in older patients with frailty. Thus, the prevalence of many oral symptoms in not known in this patient group.

The aims of this study are to determine the prevalence of oral symptoms in older patients with frailty and to determine their clinical features using the Oral Symptom Assessment Scale (OSAS) with the addition of the symptom of “drooling”.

This prospective observational study was conducted at Our Lady's Hospice and Care Services, Dublin and at St James' Hospital, Dublin. 250 participants were recruited.

METHODS

Patients aged ≥ 65 without any cognitive impairment and a Clinical Frailty Scale (CFS) score ≥ 5 were eligible for inclusion. Participants completed a modified version of the OSAS (which included the addition of the symptom of “drooling”) and feedback questions. Demographics, medications, Clinical Frailty Scale score and co-morbidities using the Cumulative Illness Rating Scale for Geriatrics (CIRSG) were also collected.

RESULTS

The median age was 82 years (range 65–99 years), and 66.4% were female. The most frequent CFS was 5 (60.4%, 151/250). The median CIRSG was 11 (range 3–30). The median number of regular medications was 10 (range 2–27). 228 participants reported at least one oral symptom. The median number of oral symptoms was 3 (range 0–13 symptoms). 93 patients experienced the “new” symptom of “drooling”.

“Dry mouth” was the most common oral symptom reported. Of the 143 participants who experienced it, 28.7% reported that it caused them “quite a bit” or “very much” distress, 65.8% reported that it occurred at least “frequently” or “almost constantly” and 83.1% reported that it was at least “moderate” or above in terms of severity.

Using the Kruskal-Wallis H test no significant difference between the number of oral symptoms and CFS score ($H(2) = 2.476$, $p = .290$) was demonstrated. The Mann Whitney U test was used to examine if there was any difference between individual oral symptoms and CFS score (significance level = .050). With the exception of “cracking of corner of mouth” ($p = .037$), these findings suggest that CFS does not significantly affect oral symptom prevalence.

Using the Kruskal-Wallis H test a statistically significant difference between the number of oral symptoms and CIRSG total score was shown (Kruskal-Wallis H test: $H(2) = 46.555$, $p = .003$). Analysis of the number of oral symptoms and CIRSG neurological score demonstrated a statistically significant difference (Kruskal-Wallis H test: $H(2) = 17.427$, $p = .002$).

There was a positive correlation between number of oral symptoms and the number of prescribed medications (Spearman's ρ rank correlation coefficient: $r_s = .220$, $p < .003$). Moreover there was a significantly difference between the number of regular medications and dry mouth ($p = .029$), cracking of corner of mouth ($p = .042$), difficulty chewing ($p = .019$), difficulty speaking ($p = .006$), coating of tongue ($p = .048$) and bad breath ($p = .028$) but not drooling ($p = .240$).

CONCLUSION

Oral symptoms are common in older people with frailty. Dry mouth and drooling appear to occur frequently, are severe and cause significant distress. There was no correlation with the of number of oral symptoms and age or gender. The number of oral symptoms was affected by the cumulative and neurological domain scores of the co-morbidity illness score scale. Frailty did not appear to affect symptom prevalence.

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Oral Symptom Assessment Scale



Title: Oral symptom assessment in older patients with frailty using the Oral Symptom Assessment Scale

Authors: Cleary, Davies, Romero-Ortuno, Lavan

Research

Title: A survey among hospital NCHDs (non-consultant hospital doctors) on use of translators to optimise communication

Authors: McDonnell, Cronin

Research



Assistance in the Estimation of Prognosis Using AKPS

R. McLernon, J. Tarrant, N. Manktelow, A. Cran
Galway Hospice Foundation

Background:
The **AKPS** (Australia-modified Karnofsky Performance Scale) score is regularly used within palliative care to assess performance status for patients. An AKPS score of 10 is taken to mean that a patient is **comatose or barely rousable**, implying that prognosis is likely to be limited.

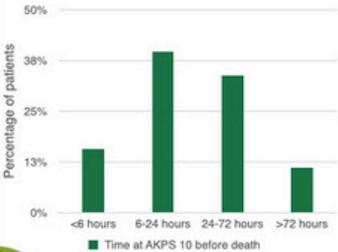
Aims and Objectives:
We wished to expand upon previous research to evaluate the time spent with an AKPS of 10 before death to assist clinicians in estimating prognosis and communicating this with family members. We hoped to better understand whether variables including location of care, gender, age and primary diagnosis may influence time spent with AKPS of 10 prior to death, and whether this may help to guide prognostication, facilitating communication and care planning as a patient's performance status decreases.

Methods:
Data from **two sites** spanning a designated six-month period was gathered retrospectively from an electronic database. Patients who did not reach an AKPS of 10 before death and patients whose precise time with an AKPS of 10 could not be determined were excluded. Demographics and clinical characteristics were summarised using descriptive statistics. Time from AKPS 10 to death (in hours) was non-normally distributed and summarised using medians. Group comparisons were performed using non-parametric tests (Mann-Whitney U and Kruskal-Wallis), and associations with age were examined using Spearman's rank correlation. Proportions of patients dying within ≤ 6 , $>6-24$, $>24-72$, and >72 hours were calculated. Statistical significance was defined as $p < 0.05$. All analyses were conducted using JASP statistical software.

Characteristics	N (%)
Total patients	154
Location:	
Mayo Hospice IPU	80 (51.9)
Galway Hospice IPU	74 (48.1)
Gender:	
Male	84 (54.5)
Female	70 (45.5)
Age:	
≤ 60	17 (11.0)
61-80	85 (55.2)
≥ 81	52 (33.8)
Diagnosis:	
Cancer	113 (73.4)
Non-cancer:	
Respiratory failure	11 (7.1)
Neurological condition	9 (5.8)
Cardiovascular disease	8 (5.2)
Renal failure	7 (4.5)
Hepatic disease	3 (1.9)
Other	3 (1.9)
Hours at AKPS 10 before death:	
≤ 6	23 (14.9)
6-24	62 (40.3)
$>24-72$	52 (33.8)
>72	17 (11.0)

Key Findings:

- Median time from AKPS 10 to death: 21.9 hours
- 55% of patients died within 24 hours
- Survival beyond 72 hours was uncommon (11%)



Results:
A total of 154 patients with an AKPS score of 10 were included. Most patients were aged ≥ 61 years (89%), 54.5% were male, and 73.4% had a cancer diagnosis. Care was provided across two inpatient units, with 48.1% in Galway inpatient unit and 51.9% in Mayo inpatient unit. Time from AKPS 10 to death was short and highly variable. Time to death differed by location of care, with longer median duration observed in Mayo IPU compared with Galway IPU ($p=0.027$). A weak positive association with age was observed ($p=0.043$). No significant differences were found by sex or diagnostic category.

Conclusion:
An AKPS of 10 was strongly associated with imminent death, most commonly within 24 hours. Demographic and diagnostic factors had limited influence, although location of care and age showed modest associations with time to death. While individual variability exists, few patients survive beyond 72 hours. These findings support an AKPS of 10 as a useful, evidence-based aid for short-term prognostication and end-of-life planning, while emphasising the continued importance of clinical judgement for individual patients.

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Acknowledgements: Research in palliative care is not possible without our patients. We are grateful to each of the patients who give our work meaning.

Title: Assistance in Estimation of Prognosis Using AKPS

Authors: McLernon, Tarrant, Manktelow, Cran

Breathlessness Management in Motor Neuron Disease: A Speech and Language Therapy and Physiotherapy Collaboration

Claire Collins, Senior Speech & Language Therapist¹ Claire Parkes, Speech & Language Therapy Manager¹
Deirdre Murray, Clinical Specialist Physiotherapist²
Sheila Sullivan, Senior Physiotherapist¹ Valerie Flood, Senior Speech & Language Therapist¹
¹Our Lady's Hospice and Care Services.
²Beaumont Hospital.



Harold's Cross
Blackrock
Wicklow



Beaumont
Hospital

Background & Case Presentation

- This case reflection demonstrates collaborative practice between speech and language therapy (SLT) and physiotherapy (PT) in an inpatient specialist palliative care (SPC) unit to optimise communication and swallowing in the context of respiratory muscle weakness associated with motor neuron disease (MND). Verbal consent was obtained.
- A female patient presented with progressive dysarthria and dysphagia, further exacerbated by increasing breathlessness. Increasing reliance on non-invasive ventilation (NIV) delivered via a face mask provided an additional barrier to communication. This resulted in reduced participation in social interactions, increased conversational breakdowns and prolonged mealtimes.
- The key objective in this case was to explore an alternative method of breathlessness management with a goal of enhancing the patient's communication and swallowing function; to support her to continue to communicate verbally and to continue to eat textured foods, and thus improve her overall quality of life.

Management

- SLT and PT worked in partnership with the patient to explore mouthpiece ventilation (MPV) (*image 1*).
- MPV is a less invasive form of NIV whereby a ventilator assisted breath is self-initiated using a mouthpiece straw.
- Communication was made with the national MND service and an outreach MPV assessment was scheduled.
- Interdisciplinary teamwork between the MND Clinical Specialist PT and the SPC SLT and PT ensured optimal MPV set up in the context of the patient's bulbar symptoms.
- Challenges in relation to lip seal, positioning of the mouthpiece clamp and ventilator settings were identified and collaborative solutions were reached to optimise the patient's NIV access and maximise her independence and confidence using the mouthpiece, while also ensuring she could engage, unobstructed, in important activities of daily living for example, drinking.
- Education regarding MPV was carried out with the patient's family and the nursing and medical teams.

Outcomes

- Quantitative outcome measures taken pre and post MPV demonstrated improvements in breathlessness for talking and eating, as well as increased vocal intensity, phonation time and syllable output per breath (*tables 1 & 2*).
- Positive qualitative data was reported in relation to improved participation in conversation, particularly in a group environment (*diagram 1*).

	Pre MPV	Post MPV
Modified BORG Dyspnoea Scale (speaking)	4 - somewhat severe	3 - moderate
Modified BORG Dyspnoea Scale (eating)	3 - moderate	2 - slight

Table 1: Outcomes Pre/Post MPV

	Without MPV	With MPV
Maximum Phonation Time	5.56 seconds	6.4 seconds
Maximum Decibel Level	80.5 dB	83.6 dB
Maximum Syllables per Breath	9 syllables	14 syllables

Table 2: Outcomes With/Without MPV



Diagram 1: Qualitative Feedback

Discussion

- This case study demonstrates that MPV can support improved communication and swallowing for patients with breathlessness associated with MND, including those with bulbar symptoms.
- Holistic interdisciplinary palliative rehabilitation enables improved symptom management and quality of life in the context of advanced illness.
- With a robust workforce there is potential to explore an onsite interdisciplinary MPV assessment service with PT and SLT. This could reduce pressure on acute services and facilitate integrated care across inpatient and outpatient settings in the future.

Conclusion

- To the best of the authors' knowledge, this is the first case reflection to explore the functional impact of MPV on supporting communication and swallowing in MND and further research is needed moving forward to build the evidence base.
- Further research is needed to explore the impact of MPV long-term, across a wider cohort of patients and with a broad range of medical diagnoses.
- To ensure holistic interdisciplinary palliative rehabilitation is developed, delivered and maintained by skilled teams, in the right place, at the right time, in alignment with the National Adult Palliative Care Policy¹ and Sláintecare², workforce planning is imperative.

Contact:
Claire Collins
Our Lady's Hospice and Care Services,
Harold's Cross,
E: ccollins@olh.ie
W: <https://olh.ie>

Company no: 352404
RCN: 20001827
CHY: 1164

Acknowledgements:
We would like express our gratitude to the patient who gave us permission to present her case and to the large multidisciplinary team involved in her care.

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Title: Breathlessness Management in Motor Neuron Disease; A Speech and Language Therapy and Physiotherapy Collaboration

Authors: Collins, Parkes, Murray, Sullivan, Flood

Research

Analysis of an Integrated Multidisciplinary Palliative Care and Respiratory 'pal-resp' Service in a Model 3 Acute Hospital

Authors: Dr Jennifer Hayes, Lisa King, Dr Liam Chawke, Dr Patricia Sheahan, Dr Noreen O' Shea, Dr Margaret Clifford.
Institution: Department of Palliative Medicine, University Hospital Kerry.

Background and Rationale

Previous research has demonstrated that integrated palliative and respiratory care improves symptom management and the quality of life of patients with advanced respiratory conditions (1,2).

Analysis of available data revealed that predominant symptoms included breathlessness (100%), anxiety (95%), low mood (90%), and fatigue (88%).

Aims and Objectives

To evaluate the integrated 'pal-resp', service in terms of patient profile, symptom burden, interventions provided and response to same.

Methods

The medical notes of patients were reviewed. Demographics, referrer, primary diagnoses, co-morbidities and oxygen requirement was recorded. Change in symptom burden following interventions were analysed using the palliative care outcome collaboration programme (PCOC).

Results

Over 13 months 38 patients were referred. 61 % were male, 39% female and the average age at time of referral was 73 years.

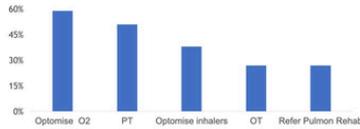


Fig. 3: interventions included optimisation of oxygen (59%), physiotherapy (45%), optimisation of inhaled therapy (38%) and 27% were referred for pulmonary rehabilitation or to occupational therapy (n=37)

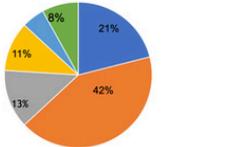


Fig. 1: 42% of patients were referred had a diagnosis of COPD combined with another significant diagnosis, 21% had a diagnosis of COPD alone. 13, 11 and 5 percent had a diagnosis of pulmonary fibrosis, interstitial lung disease and malignancy, respectively. 8% had an 'other' diagnosis (n=38)

● COPD + PF
● COPD + CCF
● COPD + malignancy

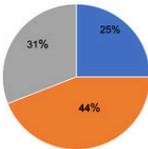


Fig 2: Of the patients referred with COPD combined with another significant diagnosis: 44% had cardiac failure, 31 % had malignancy and 25% had Pulmonary fibrosis (n=16).

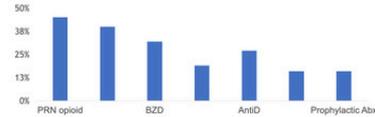


Fig. 4: Proportion of patients who were prescribed 'as required' opioids (45%), regular opioids (40%), benzodiazepines (32%), antidepressant (27%) and prophylactic antibiotics (16%). 16% had medications deprescribed. (n=37).

PCOC scores were significantly decreased following interventions for breathlessness and fatigue (n=15, P<0.05).

On presentation (94%) were in the deteriorating phase, 25% remained in the deteriorating phase and 44% entered the stable phase (n=16). 39% had their ceiling of care altered during the study period. 59% and 73% were subsequently referred to the Community Palliative Care and Palliative Care Day-Care services, respectively.

Conclusion

This research supports the efficacy of an integrated palliative care and respiratory services, which is consistent with previous research. It illustrates the predominant presenting symptoms and interventions provided.

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Title: Analysis of an Integrated Multidisciplinary Palliative Care and Respiratory 'pal-resp' Service in a Model 3 Acute Hospital

Authors: Hayes

Research

LIFE LIMITING ILLNESS IN AN ACUTE IRISH HOSPITAL

PREVALENCE, TREATMENT LIMITATION DOCUMENTATION AND OUTCOMES



AUTHORS

Cian Lannon, Niamh O'Connor, Ronan McLernon, Alison Cran, Ita Harnett

AFFILIATION

Mayo University Hospital

BACKGROUND

- Our increasing and ageing population means more people living and dying with life limiting illnesses (LLI)
- Patients with LLI often have palliative care needs, which include advance care planning and shared decision making around treatment limitations
- Failure to recognise LLI may result in these needs not being met, as well as the delivery of life prolonging treatments that are non-beneficial and/or contrary to patient or surrogate preference
- The UK Gold Standards Framework Proactive Identification Guidance (GSF-PIG) provides an objective tool that is used to identify patients who are nearing the end of their life
- The use of this tool has been well validated, but never in Ireland

AIM

To describe the prevalence of patients in an acute Irish hospital who meet the GSF-PIG criteria for LLI, the documentation and discussion of treatment limitations in this group and their outcomes in terms of mortality and hospital readmission over 1 month, 3 months and 1 year

METHOD



Design: Prospective, observational, cohort study



Participants:

- All adult inpatients on a given day in March 2025
- Patients with LLI were followed up for outcomes and mortality



Main outcome measures:

- Prevalence of inpatients with GSF-PIG criteria for LLI
- Documentation of treatment limitations and associated discussions
- Discharge destination and level of dependence
- Mortality

RESULTS



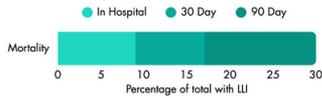
Of 243 inpatients, 77 (32%) had at least one GSF-PIG criterion for LLI



Patients with LLI who had a treatment limitation documented during their admission



Less than a quarter (21%) of documented treatment limitations were discussed with the patient



- 9% of patients with LLI died during their admission
- Nearly a third (30%) of patients with LLI had died after 90 days
- 1 year mortality not yet available (March 2026)

CONCLUSION

- The GSF PIG is a very effective tool for identifying patients with LLI in the acute Irish hospital setting
- Documentation of treatment limitations in this group is low (38%)
- Discussion of treatment limitations is even lower (21%) suggesting they are being left too late and opportunities for shared decision making are being missed

Title: Observational study of prevalence, treatment limitations and outcomes of hospitalised patients with life limiting illnesses

Authors: Lannon, O Connor, McLernon, Cran, Hartnett

Doctor's Perceptions of the Barriers to Adhering to Advanced Care Plans of Nursing Home Residents

Dr Faye Cooney¹, Dr Hannah O'Brien^{2,3}, Dr Karie Dennehy^{1,3}, Dr Tim Dukelow^{1,3}, Dr Mary McCarthy⁴, Dr Neasa Fitzpatrick^{1,3}, Dr Keith McGrath⁴
 Prof Tony Foley⁴, Dr Bart Daly^{1,3}

- Cork University Hospital
- Merumans University Hospital and Hospice
- Integrated Care Programme for the Older Person
- Mery University Hospital
- University Hospital Kerry
- University College Cork

Background

Advanced care planning (ACP) has become a routine aspect of care in many healthcare systems in developed countries¹. Despite an increase in ACP, challenges still arise when attempting to make decisions in line with a patient's documented preferences². The aim of this study is to explore the barriers perceived by different medical specialists, when attempting to make decisions in line with a patient's documented advanced care plan.

Aims and Objectives

- To gain insight into the main barriers that medical professionals encounter when caring for nursing home residents who have documented advanced care plans.
- To examine any differences or similarities in the perception of these barriers from different medical specialities.

Methods

Survey created after review of current literature. Reviewed by consultants in Geriatric and Palliative Medicine. Ethical approval was granted by CREC.

Participants were asked to rate potential barriers to adhering to a nursing home resident's advanced care plan on a scale of 1-5. A score of 1 meaning no barrier and a score of 5 being a major barrier. There were open text boxes for additional barriers or comments.

Surveys were circulated electronically to Emergency Medicine, Geriatric Medicine and Palliative Medicine Consultants and Registrars in Cork and Kerry. Electronic surveys were also sent out to General Practice (GP) trainees in the Cork and South West schemes. This was followed by a postal survey to GPs located in Cork and Kerry.

Mixed data analysis was carried out with both quantitative and qualitative analysis. The average rating of each barrier was calculated and again calculated based on different demographics.

Study Demographics

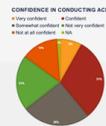
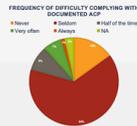


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Results

- 87 responses (electronic and postal survey)
- Response rate of approximately 9% overall
- Majority of responses came from GPs



Highest Rated Barrier - Overall: *Being unfamiliar with the resident's family*

- Average rating - 3.72
- 33% of respondents gave it a rating of 5
- Highest rated barrier amongst GPs

Lowest Rated Barrier - Overall: *The advanced care plan did not align with your own view of what is in the best interests of the resident*

- Average rating of 2.38
- 64% of respondents rating it 1-2

Emergency Medicine Consultants perceived *limited availability of community palliative medicine support out of hours and nursing home resources cannot adequately facilitate end of life care on site* as major barriers, with both receiving an average rating of 4.4. Geriatric Medicine Consultants also saw *nursing home resources at the end of life* as a major barrier, with an average rating of 3.8.

CONFIDENCE IN CONDUCTING ACP IMPACTS BARRIER RATING

- | | |
|---|---|
| <i>Documentation of the advanced care plan is difficult to obtain</i> | <i>Being unsure of the medico-legal implications of your decision</i> |
| Not at all Confident - 3.36 | Not at all Confident - 3.0 |
| Very Confident - 1.72 | Very Confident - 1.80 |

Initial qualitative analysis reveals the provisional themes of poor transfer of documentation, time constraints, medico-legal implications and familiarity with the patient and their family as notable barriers.

Conclusion

Doctor's confidence in conducting advanced care planning affected how they rated barriers particularly in relation to documentation and medico-legal implications of their decisions. This was also reflected in the comments. This suggests that across all specialities doctors may need further training and education in this area.

Hospital doctors rated barriers related to resources in the community more highly than GPs. While GPs rated barriers related to the patient and their family more highly. Which could suggest that doctors viewed factors outside their control as greater barriers.

Transfer of documentation and feedback of discussions surrounding ACP was also highlighted as a key barrier in both sets of data. With comments suggesting that collaboration between secondary care and primary care would be important to generate change in current practice. Similarly, the limited communication models between these groups was highlighted as an area that requires improvement. Transition to an electronic healthcare record may improve the transfer of information across specialities and places of care.



Title: Doctor's Perceptions of the Barriers to Adhering to Advanced Care Plans of Nursing Home Residents

Authors: Cooney, Daly, Dukelow, Dennehy, O'Brien, McCarthy, Fitzpatrick, McGrath, Foley

Research

Patients experience of a four-week exercise intervention for patients with advanced cancer under a specialist palliative care team.

Beth Carr¹, Prof Juliette Hussey², Fiona Cahill¹
¹St Francis Hospice ² Trinity College Dublin

St. Francis Hospice

Background

Exercise rehabilitation is increasingly being recognised as a beneficial component in the management of symptoms for patients with advanced cancer, in particular for fatigue and physical functioning. Energise is a physiotherapy led 4 week supervised exercise intervention, focusing on aerobic and resistance exercise for patients with advanced cancer.

Aims and Objectives

To explore participants attitudes to exercise and the lived experience of attending Energise.

Methods

Patients were invited to attend a focus group following Energise. Focus groups lasted a maximum of 35 mins. Interviews were transcribed and analysed using a thematic analysis approach.

Results

Two main themes were identified from the focus groups. 6 participants took part in the focus groups with focus group interviews lasted a maximum of 35 mins.

Concerns in engaging with Energise

- Appointment Burden
- Symptom Burden
- Transport

Positive Experience of Energise

- Physical/Psychological Improvements
- Benefits of Supervised Exercise
- Peer Support
- Environment

when you get a diagnosis like that... exercise is not a priority

Hearing other people's stories...if they can do it, I can do this

the endorphins you feel that are created, they certainly give you a massive injection of positive thinking

I've started cooking... before I hadn't the energy to do it. Now I have the energy, I have the enthusiasm.'

Conclusion

Following a four-week exercise programme, patients with advanced cancer reported a reduction in symptoms such as fatigue and breathlessness and improvements in QoL, particularly related to mood and re-engagement in household tasks.

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

sfh.ie

Title: Patients experience of a four-week exercise intervention for patients with advanced cancer under a specialist palliative care team.

Authors: Carr, Hussey, Cahill

Research

End-of-life dementia pain management at home requires teamwork, with family playing a vital role

Rosina Duffy (Community Psychiatric Nurse, WHSCT Community Mental Health Team for Older People) & Dr Deirdre Harkin (Lecturer, Ulster University)

Background: Many people living with dementia experience chronic pain, however, pain is often under recognised, under assessed and under treated in dementia care, particularly at the end of life (Carey *et al.* 2021). In Ireland, over 180,000 informal carers support a family member or loved one with dementia (Alzheimer's Society of Ireland, 2023). Due to the complex care needs of people with dementia, effective interprofessional collaboration is essential to deliver optimal palliative care (Khemai, 2022).



Aim: This scoping review aimed to explore the existing literature on pain management for people with dementia at end-of-life in their home setting.

Methodology: A scoping review was conducted guided by the Joanna Briggs Institute Framework. Electronic searches were completed using CINAHL Ultimate, Medline (Ovid), and Scopus.

Results: Eight papers were included in this scoping review. Three themes emerged:

-  The role of relatives in effective pain management
-  Communication challenges in pain management
-  The training and skills required for effective pain assessment and management.

Conclusion:

The findings highlight that effective pain management for people with dementia at end-of-life requires coordinated improvements across several areas. A collaborative approach, involving both healthcare professionals and families, is essential to ensure person centred care. Key priorities include recognising and supporting the role of relatives, strengthening communication between professionals and families, and improving education and training to promote accurate pain management.



Title: End-of-life dementia pain management at home requires teamwork, with family playing a vital role.

Authors: Duffy, Harkin

Research

Integrated Palliative Care Multidisciplinary Team (MDT) rehabilitation improved outcomes for a patient with breathlessness and anxiety



Harold's Cross
Blackrock
Wicklow
Angelic Rehabilitation Resources

Jennifer Mates, Physiotherapist; Julie Goss, Advanced Nurse Practitioner;
Dr Niall Galligan, Principal Clinical Psychologist.
Our Lady's Hospice & Care Services, Harold's Cross, Dublin.

Background

Rationale: The breathing, thinking, functioning model is an evidence-based approach to the management of refractory breathlessness. The Multidisciplinary Breathlessness Support Service (MBSS) of Our Lady's Hospice and Care Services is an Advanced Nurse Practitioner-led service including a Physiotherapy-led exercise programme, Occupational Therapy-led breathlessness classes, sessions of Clinical Psychology and Social Work support.

Case: A 67-year old lady with a diagnosis of advanced Chronic Obstructive Pulmonary Disease (COPD) and anxiety attended the MBSS in Our Lady's Hospice and Care Services (OLH&CS) between July 2024 and May 2025. The lady had become almost completely confined to her home. She no longer engaged in any community activities, apart from healthcare appointments, and had limited social interaction apart from her immediate family. The service user was using Long Term Oxygen Therapy (LTOT) for her COPD (GOLD IV). The service user used a wheelchair to mobilise outside her home. She experienced episodes of severe anxiety and breathlessness.

Aim

To improve symptoms of breathlessness, anxiety, fatigue, and the service user's Quality of Life (QoL) through MDT intervention.

Intervention

- The service user received MDT interventions from the Advanced Nurse Practitioner, Physiotherapist, Principal Clinical Psychologist, Occupational Therapist and Medical Social Worker (fig. 1).
- Outcome measures used:
 - PCOC Symptom Assessment Scale (SAS).
 - Five times Sit to Stand Test (5STS).
 - Short Physical Performance Battery (SPPB).
 - Modified Borg Dyspnoea Scale.



Fig. 1

Results

	PCOC SAS score	5STS	SPPB	Modified Borg Dyspnoea Scale
Initial Ax	Fatigue 5/10 Breathlessness 10/10	21.95 seconds	7/12	"Severely breathless"
Final Ax	Anxiety 10/10 Fatigue 0/10 Breathlessness 5/10 Anxiety 5/10	18.75 seconds	7/12	"Slightly breathless"

Feedback

- The service user returned to meaningful engagement.
- Consent for referral to community exercise class.
- Accepted social prescribing.
- Clinically meaningful difference in 5STS of >3 seconds but remained at an increased risk of falls.

"I can do the exercises more easily."

"I feel much more in control."

Key messages

- The service user demonstrated a return to community engagement, with improved psychological and functional status following an MDT approach to integrated rehabilitation in palliative care.
- The service user's symptoms of fatigue, breathlessness and anxiety improved and family carer burden was alleviated.

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Acknowledgements

Jide Afolabi, Physiotherapy Manager; Dr Clarán Haberlin, Senior Physiotherapist; Megan Walls, Senior OT; Rachel Milliar, Senior MSW; Our Lady's Hospice and Care Services.

Contact

Physiotherapy team, Specialist Palliative Care
Our Lady's Hospice and Care Services, Harold's Cross.
Email: physiopalliativecare@olh.ie
W: www.olh.ie

Title: Integrated Palliative Care Multidisciplinary team (MDT) rehabilitation improved outcomes for a patient with breathlessness and anxiety

Authors: Mates, Goss, Galligan

Research

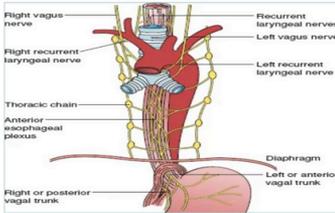
Oesophageal Syncope: A Case Study

O Mc Carthy, A Cleminson – University Hospital Kerry



Background

- Oesophageal cancer can precipitate oesophageal syncope
- Via direct or metastatic involvement of neural structures, particularly the vagus or glossopharyngeal nerve
- Presents with bradycardia and hypotension
- Rare case
- Discussed in cancer literature not in Palliative Care literature



Case Presentation

- Patient with metastatic oesophageal cancer
- Recurrent self resolving episodes of bradycardia and hypotension
- Episodes lasted approximately 5 minutes
- Increasing frequency over several weeks.

Investigations

ECG: Normal
Troponin: Negative

Management and Outcomes

- Propranolol initiated-inhibiting cholinergic receptors
- Orla therapy discontinued due to dysphagia
- Hyoscine hydrobromide transdermal patch commenced-antimuscarinic properties
- Marked reduction in frequency of syncopal episodes with good tolerability



Figure 1: Proposed pathophysiology of Oesophageal syncope in Oesophageal cancer

Conclusion

- Oesophageal syncope should be considered in patients with advanced Oesophageal cancer
- Presents with recurrent unexplained bradycardia or hypotension
- The use of topical anti cholinergic is a novel intervention not previously described in literature
- Useful when radiotherapy and steroids are not viable options

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Title: Oesophageal syncope A Case Report

Authors: McCarthy, Cleminson

Research



Developing a Regional Palliative Care Education Workshop for Home Support Health Care Assistants: An Interdisciplinary Quality Improvement Project

James Cullinan, Michael Bluett, Thomas McKeown, Ashley Byrne, Fiona Scanlon
South East Palliative Care Centre, Waterford & Wexford Public Health Nursing Teams-Home Support



Background and Context for Change

Health Care Assistants (HCAs) - Home Support provide essential frontline care to patients with life-limiting illnesses and their families in their own homes. Despite this vital role, many HCAs receive minimal formal training in palliative care. While approximately 70% of patients in Ireland express a wish to die at home, the reality is that almost 70% of patients die in hospital.

In order to address this disparity and support more people to die in their preferred place of care, we must better equip HCAs with the fundamental skills and knowledge required for delivery of palliative care. In response to a training needs analysis conducted by Assistant Director Public Health Nursing (ADPHN) - Home Support, a collaborative education initiative was developed between the South East Palliative Care Centre, Waterford and Wexford Home Support Services. This initiative aims to strengthen HCAs' knowledge, skills, and confidence in delivering high-quality palliative care to patients in their own homes.

Aim and Objectives

1. Develop a face to face interactive workshop with short teaching sessions on the fundamentals of palliative care, management of common palliative symptoms, effective communication and end-of-life care fundamentals. Advice on appropriate escalation of patient concerns to regional palliative nursing teams.
2. The first pilot workshop was delivered in Waterford and then rolled out regionally. Revisions were made as workshop feedback was given from HCAs.
3. Delivered regionally in Health Care/primary care centres by a palliative care nurses and ADPHN - Home Support to maximise accessibility and attendance by HCAs.
4. Ensure the programme emphasises self-care strategies for the HCA and signposts available Employee Assistance and organisational supports. Enable HCAs to recognise the emotional demands of caring for palliative and end-of-life patients, promoting wellbeing, resilience, and sustained quality care.
5. Facilitate discussion, sharing of experiences amongst the group and allowing for reflection on past experiences caring for patients with palliative needs.

Methods

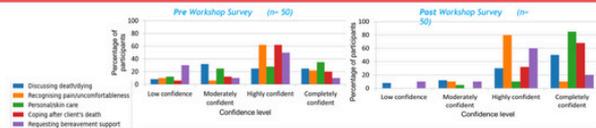
- The model for improvements plan-do-act methodology was used to achieve the objectives.
- The HSEs quality improvement toolkit was consulted and Stakeholder Analysis and Driver Diagrams tools were employed.
- A pilot education workshop was developed in Waterford, analysed and evaluated with changes implemented before the workshop programme was rolled out across the region.
- Scenario-based and reflective learning: A scenario-based learning approach was employed, in which HCAs worked through a range of palliative care scenarios in small groups. This facilitated structured reflection on previous experiences while also promoting anticipatory thinking, thereby enhancing participants' preparedness to respond effectively to potential challenges encountered when delivering palliative care in the home setting.



Results

On a scale of 0-5 how confident are you:

1. Discussing death and dying with a Patient and their family?
2. Recognising when a patient is uncomfortable or in pain?
3. Providing personal care / mouth care to a patient that is dying?
4. How well did you cope after a Patients death?
5. How likely are you to request support for grief/bereavement at work?



Discussion of Results

147 Home Support HCAs Attended 7 workshops in 5 Different Community Health Centres in 2 Counties

Key Differences: Pre vs Post Workshop:

- Overall shift toward high and complete confidence across all areas after the workshop
- Improved confidence discussing death and dying with patients and families
- Elimination of low confidence in recognising pain and discomfort
- Substantial increase in confidence providing end-of-life personal care
- Greater emotional preparedness and willingness to seek bereavement support

Some Attendee Evaluation Quotes:

- > "Being told that we were important and appreciated as carers"
- > "Was brilliant for our everyday work"
- > "Found this course very informative, feel more confident"
- > "Very calm professional educational session"
- > "The feeling of empathy in the room"
- > "Clarifying a lot of myths and language around dying"
- > "Being able to interact, exchange ideas & learn from each other in a safe space"



Sustainability

1. Simple & Effective Model, making it easy to replicate in other IHA areas.
2. The workshop was brought to the HCAs in different areas instead of all attending Regional Centre, this reduced travel times for the HCAs and Costs for HSE.
3. Afternoon delivery of the workshop was chosen to reduce any disruption to current home support services.
4. Investment in frontline healthcare staff by providing them with practical, safe & quality care interventions
5. Through facilitated group work and scenario and reflective based learning, the workshops provide the potential for peer to peer support.
6. The promotion of self-care in the workshop allows for great self-awareness of strengths and challenges when providing palliative care in the home thus reducing stress, burnout and isolation.

Conclusions

This interdisciplinary education workshop was highly effective in enhancing the skills and confidence of Home Support HCAs providing palliative care in the home setting. Participants demonstrated improved quality of care delivery and an increased ability to manage or report complex patient needs to the PHN. The workshop also positively influenced HCA wellbeing, supporting resilience in this challenging role. These findings highlight the value of interdisciplinary education in home-based palliative care and suggest a strong potential for replication and scale-up across other IHA regions.

The Five Domains of Palliative Care



Title: Developing a Palliative Care Education Workshop Programme for HSE Community Carers in the South East

Authors: Cullinan, Bluett, Byrne, Scanlon, McKeown

Research

Title: Applying the Age-Friendly Health Systems (AFHS) 4Ms Framework to Palliative Care: Insights from multidisciplinary implementation in Ireland

Authors: O Gorman, Hegarty, O Brien, Bambury

Research

AN EXPLORATION OF EXPERIENCES AND TRAINING AMONG HOSPICE STAFF DELIVERING ORAL CARE IN A PALLIATIVE CARE UNIT



Introduction

Oral care is a vital component to overall health; poor oral health has negative consequences.

Oral health conditions are common among palliative care patients requiring adequate assessment, treatment, and management.

Aim and Methods

Aim: To explore educational preparation, knowledge, practice, and continuing development needs among staff maintaining oral healthcare for patients in a specialist palliative care unit.

Design: A qualitative research design was utilised. The study took place in one inpatient unit within a hospice in one region within the United Kingdom.

Method: Participants consisted of Registered Nurses and Healthcare Assistants. Data was collected using face-to-face semi-structured interviews and subject to thematic analysis.



Results –

A total of 16 participants (8 Registered Nurses and 8 Healthcare Assistants) participated.

Thematic analysis identified three themes;

- 1) Lack of education regarding mouthcare delivery:** Significant gaps in training and education left staff feeling unprepared to deliver effective oral care, with no formal training provided during undergraduate education or hospice induction.
- 2) Performing oral care practice:** Oral care was not systematically assessed or documented and delivery was often opportunistic, with no clear policies or guidelines defining staff responsibilities.
- 3) Barriers to mouthcare delivery:** Misconceptions about patient independence, competing clinical priorities, limited time, lack of oral health products and the absence of specialised dental pathways were considered barriers to effective oral care provision.

Conclusions

Findings highlight the need for mouthcare education to be implemented within hospice settings for registered and non-registered staff.

This requires the integration of oral health education into staff induction and ongoing professional development, the establishment of clear guidelines and the creation of dental pathways.

Authors

Rebecca Crothers & Dr Felicity Hasson,
Ulster University.

For further information please email:
R.Crothers1@ulster.ac.uk

Title: A Exploration of experiences and training among hospice staff delivering oral care in a palliative care unit

Authors: Crothers, Hasson

Radiological Investigations in Patients Approaching End of Life. Retrospective Review in a Tertiary Irish Hospital.



Eva Jones¹, Ruth Cusack², Caitriona Murphy³, John Drought⁴, Fergal Howley⁵, Niall Sheehy^{2,6}, Aoibheann Conneely^{1,6,7}, Norma O'Leary^{1,6,7}

1. Specialist Palliative Care Department, St. James's Hospital.
2. Department of Radiology, St. James's Hospital.
3. Department of Radiation Oncology, St. James's Hospital.
4. Department of General Medicine, St. James's Hospital.
5. Department of Infectious Diseases, St. James's Hospital.
6. Department of Clinical Medicine, Trinity College Dublin.
7. Our Lady's Hospice & Care Services, Harold's Cross.

Contact: evajones00@gmail.com

Introduction

Radiological investigations are essential for diagnosing and treating hospitalised patients. Low-value imaging, where investigation confers little to no clinical benefit, is widespread and increasing. There is limited Irish data on radiological investigations in patients approaching end of life (EOL).

Low value imaging is imaging that does not contribute to reducing the overall pain, dysfunction or suffering of that person that is examined¹. According low value imaging can result in more harm than benefit and may not change the clinical management of a patient, or not be cost-effective¹.



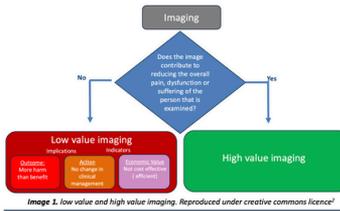
- ### Objectives
1. To describe radiological investigations and Specialist Palliative Care (SPC) input in the final four weeks of life.
 2. To describe the value of radiological investigations performed in the 72 hours prior to death.

- ### Methods
- Retrospective audit of inpatient deaths in St. James's Hospital (SJH) from Jan - June 2023
 - Chart review via Electronic Patient Record
 - Exclusion criteria: Deaths in the Emergency Department (ED), Intensive Care Unit (ICU) or within 24 hours of admission.
 - Patient demographics, SPC input, resuscitation status (Full Cardiopulmonary Resuscitation (Full CPR), Do Not Attempt Resuscitation - Active Care (DNAR-AC), DNAR-Comfort Focused Care(DNAR-CFC) and data on radiological investigations were collected for the final four weeks of life.
 - Investigations in the 72 hours prior to death were assessed as either "High value" or "low value" investigations.

Results

Demographics	Total cohort (n=284)
Age, years; mean, median	77.4, 80
Sex, female; n (%)	146 (51.41)
Length of stay, days; mean, median	32.6, 17
Number of admissions to SJH in previous 12 months; mean, median	2.14, 2
Resuscitation status: Full CPR; n (%)	22 (7.75)
Resuscitation status: DNAR-AC; n (%)	55 (19.37)
Resuscitation status: DNAR CFC; n (%)	207 (72.89)

Table 1: Patient Demographics and Resuscitation status



Results

Number of radiological investigations (n=284)	Mean	Median	Maximum
Total	5.48	5	32
X-ray	3.67	3	29
Computed Tomography (CT)	1.3	1	13
Magnetic Resonance Imaging (MRI)	0.13	0	3
Ultrasound (US)	0.2	0	3
Positron Emission Tomography (PET)	0.04	0	1
Radiology procedures	0.18	0	3

Table 2: Time of Individual Radiological Investigations in Four Weeks Prior to Death

- ### Time between final scan and death for n=284
- Mean: 6.38 days
 - Median: 4 days

- ### Specialist Palliative Care Input
- SPC consulted in n=190 (66.9%)
 - Time (days before death)
 - Mean: 7.63 days
 - Median: 4 days

- ### Value of imaging performed in 72 hours prior to death
- Total 199 radiological investigations performed in n=120 patients in the 72 hours prior to death
 - Low value: 151 (75.88%)
 - High value: 48 (24.12%)

Take home messages

Diagnostic imaging is commonly requested for patients approaching EOL; characterised by frequent imaging across multiple modalities, short interval between final imaging and death, and low value imaging. More research is needed to develop clinical guidance on avoiding low value radiological investigations at the end of life.

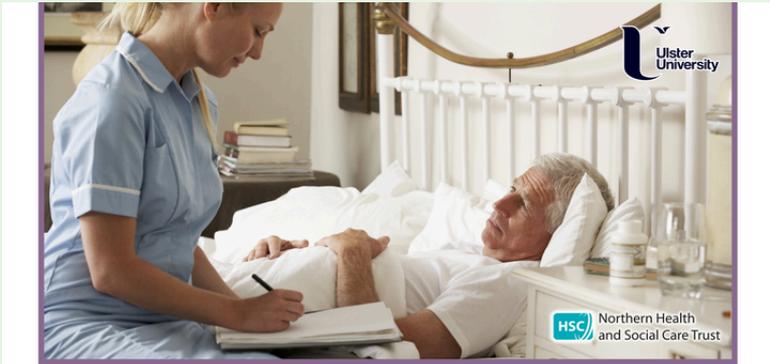
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Title: Radiological Investigations in Patients Approaching End of Life (EOL) – Retrospective Review in an Irish Hospital

Authors: Jones, Drought, Murphy, Cusack, O Leary, Sheehy

Research



A Qualitative exploration of Motor Neurone Disease family caregivers' experiences of the palliative 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.

Title: A Qualitative exploration of Motor Neurone Disease family caregivers' experiences of the palliative care keyworker

Authors: Betts, Hasson



The Use of Clonidine in Respiratory Panic: A 6 Patient Case Series from a Hospice

Authors: Dr Adrian Chapman Yan¹, Dr Rita Neves², Dr Carol Stephens¹, Dr Fatima Zia³, Dr John Curtin¹

1. Marymount University Hospital and Hospice, Cork
2. Tallaght University Hospital, Dublin
3. St Vincent's University Hospital, Dublin
E-mail: drayan@marymount.ie

Background and Aim:

The utility of polypharmacy in the management of complex symptoms is particularly useful where the use of monotherapies such as opioids may lead to tolerance and increased prevalence of side effects. Whilst the use of new drugs is exciting, carefully examining medications which are already in use by other disciplines enables us to find medications that are affordable and easily accessible. Clonidine is a drug that is commonly used by Paediatric and Intensive Care Medicine. Its action in agonising alpha-2 receptors in both the post-synaptic and pre-synaptic membranes in the brainstem centres may explain its utility in managing pain and anxiety/panic, respectively. The aim of this case series was to examine the potential utility of Clonidine in respiratory panic in a hospice setting.

Case 1: 58 ♂, Dx: Motorneurone Disease (MND)

Admitted with **dyspnoea**. Initially managed with Oral Morphine (followed by topical Fentanyl), Alprazolam (followed by Diazepam) and Olanzapine. We also employed non-pharmacological adjuncts and anti-secretaries.

Management: He was eventually commenced on a syringe driver with escalating doses of Morphine and Midazolam. After 1 week, **Clonidine** was used as a breakthrough medication, followed by being added to his syringe river at 150µg.



Outcome: He found an improvement in his breathing; this was demonstrated by a significantly reduced necessity to up titrate his Morphine.

Case 5: 71 ♂, Dx: Bulbar-Onset MND



Admitted to the hospice already reliant on non-invasive ventilation and cough assist. Respiratory secretions and sialorrhoea were prominent features; this was complicated by the patient's inability to expectorate effectively. This led to multiple episodes of **respiratory panic**. Additionally, he had spasticity and fasciculations in his right shoulder and legs which caused **pain**.



Management: He trialled a stat of **Clonidine 75µg** and found significant benefit for **pain** and **breathlessness**. However, he initially reported that it made him feel **drowsy** but was keen to continue given the symptomatic benefit. He was eventually switched to **Topical Clonidine 2.5mg** weekly.

Case 2: 84 ♀, Dx: Metastatic Squamous Cell Lung Cancer



Admitted with **pain**, **dyspnoea** and episodes of **respiratory panic**. She was on escalating doses of Morphine and Midazolam in her syringe driver.



Management: She was given a stat of **Clonidine 75µg** and this yielded significant benefit. Clonidine was therefore added to her syringe driver.

Following this, the frequency of the use of her breakthrough opioids significantly decreased.

Outcome: She reported that this enabled her to preserve better wakefulness to spend quality time with her family.

As this patient started to deteriorate, his episodes of respiratory panic worsened and he responded well to **Subcutaneous Clonidine** in his syringe driver. He received breakthrough medications including Morphine, Midazolam, **Buscopan** and Clonidine. Outcome: he reported they all gave him periods of benefit, demonstrating the opioid/benzodiazepine-sparing capability of Clonidine.

Case 6: 57 ♀, Dx: Multiple Sclerosis



This lady presented with **dyspnoea** and significant difficulty clearing secretions, leading to episodes of hypoxia and **respiratory panic**.

Management: She was prescribed **Buscopan** and Clonidine as part of her breakthrough regimen. The former initially helped, however, the latter provided greater symptomatic benefit and was added to a syringe driver. A combination of both the Buscopan and the Clonidine **enabled the patient to clinically stabilise**.

Outcome: She was eventually changed to topical preparations of both. Post-discharge to the nursing home, she remained stable.

Case 3: 81 ♀, Dx: MND



Admitted with recurrent episodes of **respiratory panic**, with increasing reliance on non-invasive ventilation. This patient had an aversion to opioids and was hesitant to use them, even as a breakthrough medication. This stemmed from concerns about potential side effects and dependence.

Management: Respecting his autonomy, we trialled of **Subcutaneous Clonidine 75µg**. Encouraged by the response, he was commenced on a Clonidine patch and derived good symptomatic benefit.

Outcome: As his clinical condition progressed, the dose of Clonidine was increased; however, this did not alleviate his symptoms until Morphine was introduced alongside it. **This demonstrates a potential limitation of Clonidine as a monotherapy with less titration flexibility.**

Case 4: 69 ♀, Dx: Oesophageal Squamous Cell Carcinoma



This lady's tumour directly infiltrated into the posterior tracheal wall, carina and bilateral bronchi. She had consecutive hospital admissions with progressive **dyspnoea** and was started on a syringe driver. Whilst in the community, multiple attempts were made to wean down the syringe driver unsuccessfully.

Management: Shortly after admission, **Clonidine** was added to her syringe driver. Subsequently, her breakthrough opioid use significantly decreased; this led to a reduction in the morphine dose in her syringe driver.

Outcome: Later in her admission, she developed an aspiration pneumonia and deteriorated overall. **The Clonidine in her syringe driver had to be withdrawn due to symptomatic hypotension.**

Discussion and Conclusions

There may be potential in exploring drugs commonly used by other disciplines and translating their practices to optimise quality of life; these drugs are often cheap and accessible. In this case series, we have demonstrated the potential opioid/benzodiazepine-sparing capability of Clonidine. As a result, one case even reported preserved wakefulness to spend better quality time with their family. However, another case reported drowsiness; this heterogeneous effect may need to be explored further.

A potential limitation we encountered included symptomatic hypotension, particularly when compounded by other factors. Additionally, when deteriorating, there was also limited titration flexibility with Clonidine.

It would be important to build on this case series with feasibility cohort/randomised control trials to explore the potential further.



Title: The Use of Clonidine in Respiratory Panic: A 6 Patient Case Series from a Hospice

Authors: Chapman Yan, Neves, Zia, Curtin

Research

Retrospective study to determine patient characteristics and pathways through a hospice-based outpatient and day service; Interim results

Brenda O'Connor^{1,2}, Patricia Kinsella¹, Julie Donohoe¹, Mainlad Doherty^{1,3}, Fiona Cahill¹, Una Molloy¹, Sarah Delaney¹, Beth Carr¹



St. Francis Hospice

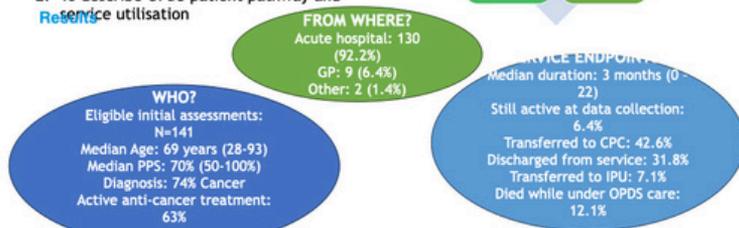
Background

The Outpatient and Day Service (OPDS) provides specialist palliative care (SPC) for ambulatory patients. It incorporates a palliative rehabilitation model using a holistic interdisciplinary approach rooted in the hospice's core values. Ambulatory care facilitates earlier access to palliative care for an evolving population. Care is delivered through individual appointments and therapeutic group work. Defining the specific needs of our OPDS population is essential for service development and efficient resource use.

Aims

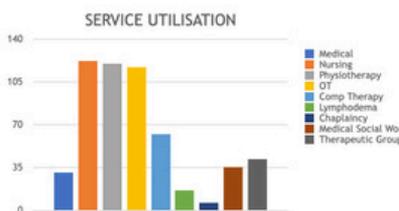
1. To define the characteristics of the OPDS patient population
2. To describe OPDS patient pathway and service utilisation

Results



Methodology

1. Retrospective review of healthcare records from OPDS initial assessments in 2023 who consented to data collection for quality improvement.
2. Descriptive statistics were generated through Microsoft Excel.
3. Local research ethics committee approval.



Conclusions

1. The OPDS population mostly comprised cancer patients undergoing anti-cancer treatment.
2. Most were referred through acute hospitals.
3. The majority had a good performance status and engaged well with palliative rehabilitation practice.

4. Future research will further define individual patient cohorts and explore how a greater understanding of the ambulatory population will help to refine SPC input and patient pathways to inform service development. Education for referring services will be essential.

1. St Francis Hospice Dublin
2. Mater Misericordiae University Hospital
3. University College Dublin

www.sfh.ie

Title: Retrospective study to determine patient characteristics and pathways through a hospice-based Outpatient and Day Service

Authors: O Connor, Kinsella, Donohue, Doherty, Cahill, Molloy, Carr, Delaney

Research



Assessment and revision of a shared proforma to guide and document discussion at a Specialist Palliative Care Inpatient Unit Multidisciplinary Team Meeting



Sarita Ankatiah, Ann McAtamney, Liz Reidy, Margaret Clifford, Patricia Sheahan
Kerry Specialist Palliative Care Services

BACKGROUND

Previously, a nurse manager completed a discussion summary at the weekly SPC IPU MDTM, which was then filed in a separate folder, not easily accessible to the wider MDT. The other MDT members documented parts of the meeting discussion separately in their own clinical notes. This led to confusion with slightly different versions of the same discussion being documented in different places.

OBJECTIVES

- 1) To create a comprehensive, user-friendly proforma to be filed into the clinical notes after completion
- 2) To encourage medical staff and MDT to partake in completing the revised proforma

METHODOLOGY

- A proforma was drafted, incorporating key clinical and palliative care concepts, physical, psychological, social and spiritual issues, discharge planning, bereavement/carer concerns, options for treatment escalation plans and place of care.
- After a 5-month trial of the new proforma, feedback was sought from staff (doctors, nurses, MDT) via paper questionnaire, along with chart review over 8 weeks to assess compliance with completion.

RESULTS 1: Table illustrating level of completion of revised proforma

Documentation	% (n=30)
Physical issues and plan	100%
Psychological issues and plan	80%
Social/spiritual/carer/bereavement issues and plan	70%
Discharge issues and plan	97%
PCOC scores (except SAS)	93%
Treatment escalation plan	90%
Place of care	90%

RESULTS 2: Table showing the results of staff questionnaire

Question	% (n=9)
Rated revised proforma as good and/or very good	89%
Easy to complete and contains key information	100%
Prefer revised proforma over previous – detailed, user friendly	89%
Is filing it in the chart a good idea? – easily accessible to reference	100%
Have you completed the revised proforma?	89%
Barriers to completion – uncertainty of what to document; doing other tasks	11%; 11%

CONCLUSION

Overall feedback and completion of the revised form was excellent. Recommendations for improvement included increasing space for physical issues, combining psychological and spiritual problems, reordering PCOC scores and including STOPP-Frail tool checkbox, designation and professional number. Interventions will be updating form, staff education and assessment in two months.

Title: Assessment and revision of a shared proforma to guide and document discussion at a Specialist Palliative Care Inpatient Unit (SPC IPU) Multi-Disciplinary Team Meeting (MDTM)

Authors: Ankatiah, McAtamney, Reidy, Clifford, Sheahan

Research

Personal and Professional Perspectives on Advance Care Planning Among Palliative Care Staff in Ireland

Gleeson¹, T., McQuillan², R., Pilch¹, M.

¹University College Dublin, ²St. Francis Hospice and Beaumont Hospital

Introduction

- Advance Care Planning (ACP) is a collaborative process where individuals discuss and document future care preferences.
- Despite positive outcomes, uptake and awareness remains low.
- Irish ACP legislation is quite recent, and there is limited research on ACP in an Irish context.

Aim: To explore factors associated with ACP engagement for self and others among palliative care staff.

Predictor Variables

- Perspective Taking
- Fear of Death
- Compassion Fatigue
- Palliative Care Self-efficacy
- Religious Beliefs

Outcome Variables

- ACP for:
- (1) Self
 - (2) Loved Ones
 - (3) Patients

Methods

Cross-sectional survey of palliative care staff ($n = 105$) in Ireland.

Explored:

- Differences in ACP Engagement across three contexts: Self, Loved Ones, Patients.
- Associations between predictor variables and outcome variables.
- Qualitative analysis of exploratory question.

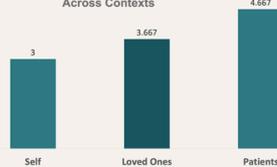
Results

Significant Correlations

	Loved Ones		Patients	
	ρ	Sig.	ρ	Sig.
Fear of Death	-.213	.015	-.168	.05
Psychosocial Self-Efficacy			.288	.002
Symptom Management Self-Efficacy			.295	.002

- 80.6% supported patients in speaking about future care.
- 10.5% discussed their own future care with their doctor.
- Discussion-based behaviours more common than official behaviours.

Median ACP Engagement Across Contexts



- ACP is a professional duty, not a personal priority for palliative care staff.
- Confronting mortality, bringing everyone to agreement, and fear of distressing others cited as barriers.

Conclusions

- ACP is prominent in palliative care.
- Perception that ACP is only for those with health issues.
- Impact of psychological factors lower than expected.

Future Research

- Longitudinal research is needed to explore how ACP engagement evolves over time.
- Interventions that both raise awareness of ACP and target issues influencing non-engagement may be necessary.



Contact: tadhg.gleeson@ucdconnect.ie

Title: Personal and Professional Perspectives on Advance Care Planning Among Palliative Care Staff: An Observational Study

Authors: Gleeson, McQuillan, Pilch

Research

Management of Diabetes Mellitus at the End-of-Life - Adherence to local hospital guidance

Dr Molly Dinneen, NCHD, Dr Mairéad Doherty, Consultant in Palliative Medicine
1. Specialist Palliative Care Department, Mater Misericordiae University Hospital, Dublin 7, Ireland



INTRODUCTION

The aim was to evaluate adherence to the local Mater Misericordiae University Hospital (MMUH) guidance on the management of diabetes mellitus at the end of life (EOL). The objectives of the audit were to (1) enhance the management of insulin therapy and hypoglycaemia at the EOL; (2) ensure appropriate communication and documentation surrounding diabetes at the EOL; (3) improve adherence to the Guideline for Diabetes Management at the EOL at MMUH; (4) to evaluate and promote appropriate use of the supplementary insulin sliding scale; (5) improve management of blood glucose monitoring at the EOL. The Guidance for the Management of Diabetes Mellitus at the End of Life was the standard used for comparison.

METHODS

- Patients who died under the specialist palliative care team in the MMUH with a diagnosis of diabetes were identified from the electronic medical records system Patient Centre
- A pseudo-anonymised, retrospective chart review was undertaken
- 162 patients were screened from January 2025 to April 2025
- 30 patients were identified
- Descriptive data was formulated on Microsoft Excel

RESULTS

N = 26 (2 files not found, 2 patients records online and unobtainable)
All 26 patients had Type 2 Diabetes Mellitus
7 patients were on insulin

- Standard 1: Met in 4/26 (15.38%)
- Standard 2: Met in 11/26 (42.3%)
- Standard 3: Met in 23/26 (88.46%)
- Standard 4: Met in 22/23 (95.65%)
- Standard 5: Met in 4/7 (57.14%)
- Standard 6: Met in 4/7 (57.14%)
- Standard 7: Was not met in any patients (0%)

The figure illustrates the results from the previous audit in 2024.

CONCLUSION

This re-audit findings indicate that while communication regarding diabetes management at the end of life has shown measurable improvement, insulin management and documentation in this patient group remains an area requiring further attention. Compared to the previous audit cycle, where all standards demonstrated improvements following targeted education and increased policy awareness, this cycle highlights the need for renewed focus specifically on insulin use. Given the evolving research in this area, it is recommended that the relevant standards be reviewed and updated accordingly. Additionally, further education and training initiatives should be implemented to enhance clinical understanding and practice around insulin management at the end of life, ensuring alignment with current evidence-based guidelines

NEXT STEPS

- **Guideline Review (2026):** Re-evaluate the "Guidance for the Management of Diabetes Mellitus at the End of Life" in light of emerging research.
- **Education & Awareness:** Increase targeted training for doctors and nurses on insulin management and reinforce policy awareness.
- **Re-Audit:** Repeat the audit in the next PDSA cycle to monitor progress and impact of interventions.
- **Policy Flagging:** Ensure the policy is documented and flagged in patient charts to alert clinical teams and support consistent care
- **Internal:** present the audit findings to the Mater Specialist Palliative care team at it's weekly Medical Decision Making (MDM) meeting

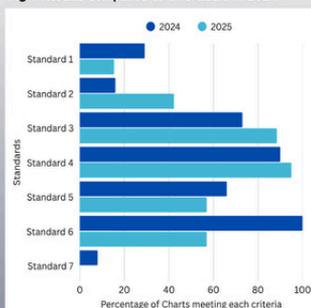
References

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

STANDARDS

1. Clearly documented decision-making surrounding diabetes management at EOL
2. Evidence of appropriate communication with patient/family regarding diabetes management at EOL
3. Blood glucose level testing appropriately reduced/stopped as a person approaches the EOL
4. Oral hypoglycaemic agents appropriately discontinued as a person approaches EOL
5. Insulin is reduced when oral intake diminishes
6. Basal insulin maintained until patient is unconscious/actively dying?
7. Use of the supplementary EOL sliding scale

Fig 1 Results compared to a re-audit in 2024



Percentage of Charts meeting each criteria

Acknowledgements

Dedicated work from the Palliative Care Team at the MMUH

Title: Management of Diabetes Mellitus at the End of Life – Adherence to Local Hospital Guidance

Authors: Dinneen, Doherty

Research

Title: A National Survey of Kidney Supportive Care Services in Ireland

Authors: Mackey, Lowney, O'Brien, Moran, Long, Plant, Curtin

Research

Hospital-Wide Assessment of Self-Reported Competence in the Provision of Palliative Care to Patients with Life-Limiting Conditions and their Families at Portiuncula University Hospital: A Cross-Sectional Survey

Dr Seán Killeen, Dr Chris McBrearty, Ms Helen Ely, Dr Kathleen Cronin, Dr Sharon Beatty
Portiuncula University Hospital, Ballinasloe, Co. Galway, Ireland

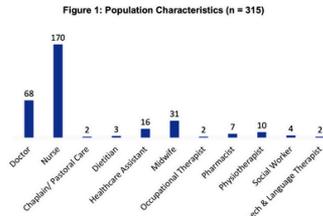
Background

- Palliative care competence is essential for all healthcare professionals caring for people with life-limiting illness.
- The Irish Palliative Care Competence Framework (PCCF) defines core and role-dependent competencies across disciplines.
- However, limited evidence exists describing self-reported palliative care competence across multidisciplinary hospital workforces.

Research Aim

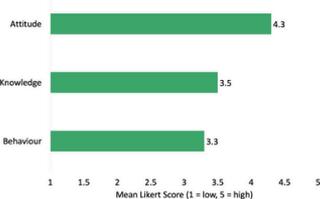
- To assess self-reported palliative care competence across attitudes, behaviours, and knowledge among healthcare professionals in an acute hospital and identify areas of relative strength and potential educational need to inform workforce development.
- To raise awareness of the PCCF among healthcare professionals.

Results



Distribution of survey respondents by professional group (n=315), representing approximately 50% of eligible staff in Portiuncula University Hospital

Figure 2. Mean self-reported palliative care competence across attitude, behaviour, and knowledge domains



Bar chart showing mean self-reported competence scores across the three palliative care domains of attitudes, knowledge, and behaviours among healthcare professionals. Scores represent overall mean Likert-scale ratings for all respondents combined.

Methodology

Design: Cross-sectional survey.

Setting: Portiuncula University Hospital, Ballinasloe, Co. Galway, Ireland.

Participants: All healthcare professionals outlined in the PCCF and employed at the hospital, including medical, nursing, midwifery, allied health, healthcare assistants, and pastoral care staff.

Instrument: Framework-aligned questionnaire assessing self-reported competence across three domains: Attitudes, Behaviours, Knowledge¹. Participants rated items in relation to their own role and scope of practice, reflecting the PCCF's graded competence approach.

Analysis: Descriptive statistics only; no between-group statistical comparisons.

Figure 3. Heat map of selected palliative care competence items across healthcare professionals

	Attitude	Behaviour	Knowledge
Doctor	4.2	3.4	3.6
Nurse	4.4	3.4	3.7
Chaplain/ Pastoral Care	4.7	4.0	4.8
Dietitian	4.1	2.6	2.4
Healthcare Assistant	4.3	2.5	2.7
Midwife	4.1	3.1	3.1
Occupational Therapist	4.0	3.2	2.6
Pharmacist	4.1	2.5	2.5
Physiotherapist	4.3	3.1	3.1
Social Worker	4.8	3.8	3.4
Speech & Language Therapist	4.3	3.5	3.3

Heat map showing mean self-reported competence scores for selected palliative care questionnaire items among healthcare professionals. Rows represent professional groups and shading intensity reflects level of perceived competence, with darker shading indicating higher scores.

- 315 healthcare professionals from across medical, nursing, midwifery, allied health, healthcare assistant, and pastoral care roles completed the survey.
- Mean self-reported competence varied by domain, with highest scores observed in attitudes, followed by behaviours, and lowest scores in knowledge.
- Attitudinal competence was consistently high across respondents, reflecting strong alignment with palliative care values.
- Behavioural competence showed greater variability, with lower scores for items involving leadership, advance care planning, conflict mediation, and complex communication.
- Knowledge-based competence was lowest overall, particularly for complex symptom management, prognosis, and identifying appropriate timing for a palliative care approach.
- Lower scores clustered around role-dependent or clinically complex competencies as defined by the Palliative Care Competence Framework.

Conclusion

Using a questionnaire aligned with the Irish Palliative Care Competence Framework, this study shows that healthcare professionals report strong alignment with palliative care values, alongside lower perceived competence in behavioural and knowledge-based, role-dependent competencies. The questionnaire is a useful descriptive tool for assessing workforce-wide self-reported competence, and to inform educational initiatives both at a local and national level.

References

- Cassidy M, Callaghan C, O'Shea E, et al. Self-reported responses to palliative care among physicians in Ireland. *BMJ Support Palliat Care*. 2018;8(4):399-406.
- Health Service Executive. Palliative Care Competence Framework. Dublin: Health Service Executive; 2014.

Contact information: Seán Killeen seanjilleen@gmail.com

Title: Hospital-Wide Assessment of Self-Reported Competence in the Provision of Palliative Care to Patients with Life-Limiting Conditions and their Families at Portiuncula University Hospital: A Cross-Sectional Survey

Authors: Killeen, McBrearty, Cronin, Beatty, Ely

High-Flow Nasal Oxygen for Community Palliative Care patients: A Case Series

Sarah Nestor¹, Maria Alvarez², Camilla Murtagh^{1,2}



¹Galway University Hospital
²Galway Hospice Foundation



Background and Rationale

Refractory dyspnoea is a highly prevalent and distressing symptom in patients with advanced respiratory disease receiving palliative care.¹ High Flow Nasal Oxygen (HFNO), otherwise known as AIRVO™ (Fig. 1), has emerged as a significant non-invasive support and has transformed care of patients with advanced respiratory illness.² HFNO delivers heated, humidified gas at high flow rates and improves comfort, reduces dyspnoea, and facilitate discharge home. Evidence for its use in palliative and end-of-life care, particularly in community settings, remains limited.



Aims and Objectives

To describe patient characteristics, indications, symptom response, outcomes, and resource utilisation associated with HFNO use in a palliative care inpatient and community setting.

Methodology

This retrospective descriptive case series included five patients commenced on HFNO in an inpatient palliative care unit (IPU) between 2024–2025 and subsequently discharged to the community on HFNO. Ethical approval was secured from the local clinical research ethics board and informed consent was obtained from either patients or family members in each case. Data were extracted from clinical records and included demographics, Australia-modified Karnofsky Performance Status (AKPS), Symptom Assessment Scale [SAS], Borg dyspnoea scale, O₂ requirements, HFNO settings and duration of therapy, adverse events, outcomes, and community palliative care (CPC) resource utilisation.

Demographics

ID	Age	Primary diagnosis	Discharge destination	Total HFNO duration
1	80	Ischaemic pulmonary fibrosis	Home → Hospice	94 days
2	75	Ischaemic pulmonary fibrosis	Home → Hospice → Home	334 days
3	66	Pulmonary fibrosis (Blebs related)	Home → Hospice	109 days
4	80	Ischaemic pulmonary fibrosis	Home	48 days (ongoing)
5	72	Advanced COPD	Home → Hospice	133 days

Table 1.

Indications for HFNO

All patients were receiving supplemental oxygen prior to HFNO initiation. In all cases, HFNO was commenced for refractory dyspnoea characterised by increased work of breathing, desaturation, and patient discomfort despite optimization of conventional pharmacological and non-pharmacological therapies. Pre-HFNO SAS scores ranged from 4–7/10. Where recorded, Borg dyspnoea scores ranged from 4–7/10, including severe dyspnoea on minimal exertion despite oxygen saturations within target ranges.

HFNO Tolerability and Discharge

Initial HFNO settings varied between patients but typically included temperatures of 34–37°C, flow rates of 40–50 L/min, and FiO₂ of 21–45%. All patients required some degree of individualised titration. HFNO was overall well tolerated. Transient difficulties with sleep or discomfort were reported in three patients and resolved with flow or temperature reduction.



Length of IPU stay on HFNO ranged from 11–21 days. All patients were successfully discharged to the community on HFNO, with no reported delays in equipment provision. One patient required two high-flow concentrators at home due to high oxygen demands.

Symptom Response

All patients demonstrated improvement in dyspnoea following HFNO initiation. Post-HFNO SAS scores reduced to 2–4/10 shortly after commencement, with further improvement or sustained low scores over time. Borg dyspnoea scores, where recorded, improved by approximately 2–4 points at rest, alongside observable reductions in work of breathing, improved speech fluency, and patient-reported comfort. Notably, one patient with advanced COPD experienced symptomatic benefit on HFNO delivered with room air (FiO₂ 21%), suggesting reduction in work of breathing rather than oxygenation alone contributed to relief.

Duration, Outcomes and EOLC

Total duration of HFNO therapy ranged from 34 days (ongoing at time of reporting) to 384 days, demonstrating feasibility of prolonged community use. Four patients died during the study period: two at home and two in an inpatient hospice setting. Three patients underwent planned HFNO weaning prior to death, guided by goals of care and family discussions. Weaning approaches were individualised rather than protocol-driven and were supported by anticipatory prescribing of opioids and benzodiazepines. In all cases, symptom control at end of life was reported as good, with SAS scores ≤3/10 at the time of death where recorded. Readmissions occurred in four patients, related to global clinical decline, symptom exacerbation, infection, or inability to maintain HFNO at home during power outages. Of note, two patients experienced power outages that interrupted HFNO therapy, necessitating emergency oxygen use or hospital readmission. These events highlighted the importance of contingency planning, backup power solutions, and caregiver education.

Implications for Practice

Patient selection
- Advanced respiratory disease with refractory dyspnoea despite optimal medical management
- Clear goals of care focused on comfort and quality of life

Symptom control
- Through individualisation of flow, temperature, humidification, and improved comfort – not solely oxygenation
- Can be used as a bridge to end-of-life (EOL) decisions

Enabling care at home
- HFNO can facilitate discharge and promote continuity of care, including life at home
- Requires early coordination with community palliative care services and equipment providers

End-of-life management
- HFNO can be continued, weaned, or withdrawn in alignment with patient and family goals
- Shared, individualised meetings with anticipatory prescribing supports comfort and avoids prolongation of dying

Service and safety considerations
- High multidisciplinary resource use and safety and pharmacy input should be anticipated
- Robust contingency planning for power failure (backup oxygen, generators, education) is essential

Conclusions

HFNO represents a valuable non-invasive intervention for refractory dyspnoea in advanced respiratory disease. In this case series, HFNO supported meaningful symptom relief, enabled time at home, and goal-concordant care, including planned withdrawal at end of life. Its use requires careful patient selection, proactive community support, and explicit advance planning, but may significantly enhance quality of life for selected palliative care patients.

References

1. "High-flow oxygen therapy in palliative care: A reality in a near future?" (Duarte et al., 2021)
2. A Comprehensive Review on High-Flow Nasal Cannula Oxygen Therapy in Critical Care: Evidence-Based Insights and Future Directions? (Pettifor et al., 2024)

Title: High flow nasal oxygen in community palliative care: a case series

Authors: Nestor, Alvarez, Murtagh



Rialtas na hÉireann
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The Hospital Saturday Fund

IAPC would like to gratefully acknowledge the funding received through the Hospital Saturday fund to support the 2026 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 2026. This is a prestigious award and we are grateful to Dr. Declan Walsh for continuing to support this initiative.



IAPC are appreciative of the continued sponsorship of Nutricia to our Education and Research Seminar.



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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 areas 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.

Irish Association for Palliative Care

Carmichael House, 4 Brunswick Street North, Dublin 7 D07RHA8

TEL: 01 873 4735

FAX: 01 873 5737

EMAIL: info@iapc.ie

TWITTER: [#palcaressem22](https://twitter.com/palcaressem22)

www.iapc.ie for more information and on-line membership application