'Living well with advancing illness – An interdisciplinary rehabilitative palliative care approach to patient care'

Palliative Rehabilitation Seminar

Ashling Hotel Dublin, Wednesday 11 June 2025

Poster Abstract Book

AIIHPC
All Ireland Institute of
Hospice and Palliative Care

Facilitating interdisciplinary working between staff working directly with patients in a Specialist Palliative Care (SPC) Outpatient department.

St. Francis Hospice

Ciara Hiney [1], Sarah Delaney [1], Bernadette Doohan [2] & Isabelle McDonnell [2]

Background

An integrative review of interprofessional team in SPC found that communication, collaboration and clear goals impacted teamwork and dynamics (Kesonen et al 2022). This study investigated staff members' experiences of interdisciplinary working in a new Specialist Palliative Care Outpatient department.

Objectives:

To explore factors, qualities and competencies which contributed to, and hindered, effective interdisciplinary working.

Methods:

All employees in direct patient-facing roles were invited to participate in the study, which was approved by the Research Ethics Committee of the service site. 11 participants engaged in three focus groups using a semi-structured interview format. Focus groups were facilitated by an independent researcher and held over a 6-month period.

Results:

Thematic analysis was used to identify key findings from the focus groups.

Enablers

Teamwork	Evolution of specialist Palliative Care
Mentorship	Shared Vision

Barriers

Organizational	Resources
Loss of Professional Identity	Education

Conclusion:

- ✓ Interdisciplinary working improved collaboration between different disciplines, and networking, with external stakeholders
- ✓ Staff valued feeling included and working collaboratively as part of a team.
- ✓ Staff felt that the quality of patient care, and patients' perceptions of palliative care had improved.

Lessons Learned:

Change management training, along with incremental changes, would have provided more support to staff during the transition period. Vital skills include effective communication and listening, both from management, and between disciplines, to support interdisciplinary working. Increased staffing may also be a facilitator.

Further Development Plans:

- Attendance at St Christopher's Masterclass on Interdisciplinary Working
- Subgroup to improve processes
- Introduction of change management workshops ahead of site redevelopment

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St. Francis Hospice

Breathlessness in Everyday Life:
An Occupational Therapy Group Intervention Programme in Community Palliative Care

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Background

- Breathlessness is a common and distressing symptom experienced by many individuals with chronic respiratory and other advanced illnesses. Breathlessness can significantly impact people's quality of life and ability to perform everyday activities. It is strongly associated with anxiety and panic, often further limiting people's ability to engage in community and social activities[1].
- 25% of referrals received for the Occupational Therapy outpatient service are for breathlessness management.
- **Objective:** (1) To develop a 4-week group intervention programme for individuals experiencing breathlessness and availing of community palliative care services, aimed at reducing the impact of breathlessness, enhancing quality of life, and providing peer and social support. (2) To evaluate the effectiveness of the group intervention programme and gather feedback on service delivery, to inform how best to deliver symptom self-management group interventions for individuals with SPC needs.

Figure 1: Intervention Underpinned by The Breathing, Thinking, Functioning Model.

Method and Actions

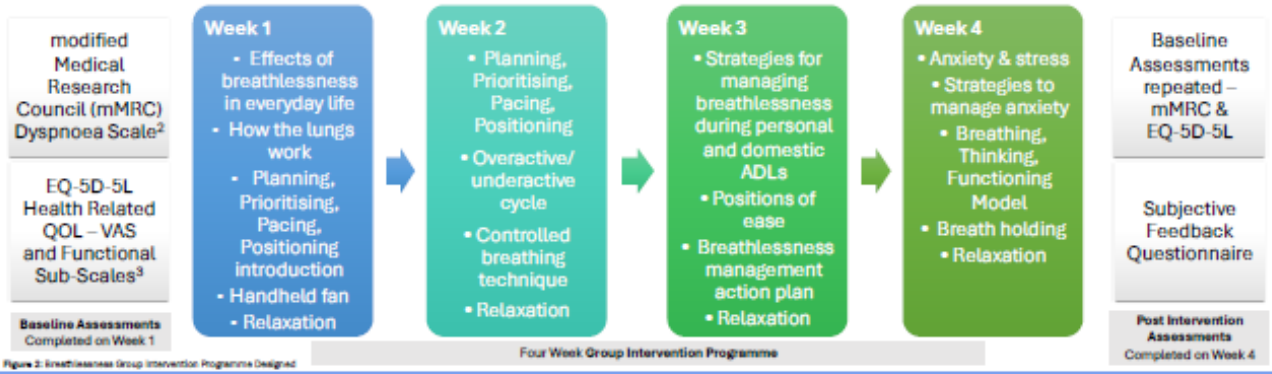

Figure 2: Breathlessness Group Intervention Programme Designed

Results

- 10 group cohorts were facilitated over 16 months with 38 participants.
- Pre and post intervention data were gathered for 19 participants.

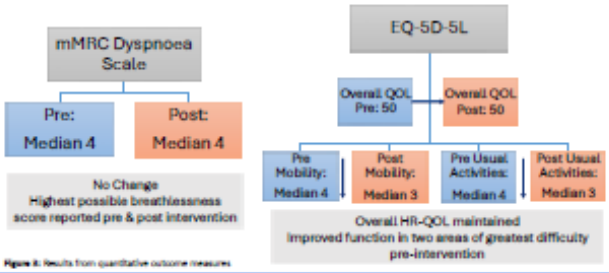

Figure 3: Results from quantitative outcome measures

- Feedback questionnaires were obtained from 22 participants.

Improved Breathing Mastery - 86% '*agreed*' or '*strongly agreed*' that they were better able to manage their breathlessness post intervention.

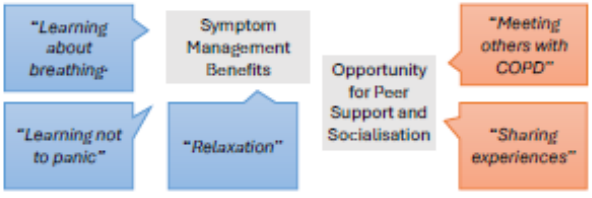

Figure 4: Self-perceived benefits of the group intervention reported by participants

Participant Feedback & Changes Implemented

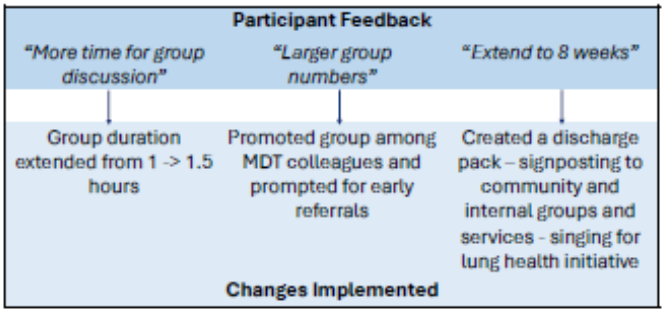

Figure 5: Examples of changes implemented to the group programme based on feedback received by participants

Conclusion and Reflection

- This group intervention programme enhanced symptom self-management efficacy, offered valuable peer support and optimised function with mobility and usual activities, for community-dwelling patients, living with chronic breathlessness.
- These participants were significantly limited by breathlessness pre-intervention, which may explain the lack of change observed post-intervention, on the mMRC dyspnoea scale.
- To optimise the impact of this rehabilitative intervention in preserving function and independence, it is important to consider timing of delivery and identify participants before they are chronically affected by breathlessness.

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Acknowledgements:
We would like express our gratitude to the many patients who have participated in this intervention to date and provided invaluable feedback and to our MDT colleagues for their ongoing collaboration and support.

References:
1 Ekström et al., (2015) The management of chronic breathlessness in patients with advanced and terminal illness. DOI: doi-org.ellib.tcd.ie/10.1136/bmj.g7617
2. Mahler et al., (1988) Evaluation of clinical methods for rating dyspnea. DOI: doi:10.1378/chest.93.3.580
3. Herdman et al., (2011) Development and preliminary testing of the new five-level version of EQ-5D (EQ-5D-5L). DOI: doi.org/10.1007/s11136-011-9903-x

Fatigue Anxiety and Breathlessness (FAB) Programme

Authors: Liz McNabney Occupational Therapist, Julie Hamilton Physiotherapist and Emily Jackson Nurse
Marie Curie Hospice (Outpatients Department) Belfast

Introduction

The Fatigue Anxiety and Breathlessness Programme is designed to support people aged 18 and over who have a life limiting condition for whom breathlessness is a key symptom but who also experience anxiety and fatigue. It is a multidisciplinary led programme held over 5 consecutive weeks.
While, initially developed as an online programme during COVID, the face-to-face programme has been held on a regular basis for the last 4 years in the Marie Curie Hospice outpatient department in Belfast.

Aims of Programme

- To enable patients to understand the symptoms of their illness.
- To support patients, implement techniques and coping mechanisms to relieve and manage their symptoms.
- To assist patients, achieve their best possible quality of life.
- To provide a forum for discussion and sharing concerns and experiences. Peer interaction and support cannot be underestimated.

PATIENT FEEDBACK –

' The staff were very attentive and able to answer my concerns. This made for a very helpful and relaxed time.' - James

'The sessions were very informative ' - Miriam

' I felt very supported by the staff. The information given to us was extremely useful" - Margaret

Referrals

Referrals are received from a range of professional staff including General Practitioners, Respiratory Nurse Specialists, Clinical Nurse Specialists and AHP staff.
A screening assessment is undertaken with each patient to establish essential information such as :

- Oxygen requirements
- Mobility
- Car transfers
- Transport to/from the programme

The Programme

- Is held over 5 consecutive weeks in the out-patient department:-
  Week 1 – Introduction -Lead by OT
  Week 2- Managing anxiety- Lead by OT
  Week 3 - Managing breathlessness – Lead by PT
  Week 4- Medications / oxygen management – Lead By Nursing
  Week 5 – Managing Fatigue –Lead by OT
- As well as advice and information on the key symptoms, gentle exercise is incorporated into the programme
- Practical strategies and techniques to manage breathlessness , anxiety and fatigue are taught within the programme.

Outcomes

- Approximately 50 + patients attended FAB a programme in Marie Curie Outpatients Department in 2024
- Patient feedback has been 100% positive
- Patients appreciate the opportunity to meet with others who are experiencing similar symptoms
- Increasing numbers of close family members also wishing to attend
- Closer working relationships developed with external respiratory teams

Marie Curie

Advanced Cancer Online Health & Well-Being Toolkit

Alison Craig & Anne O'Hagan Macmillan Palliative Care Service Improvement Team, NHSCT

Background

In 2022 NHSCT Service Users (SU) and Professionals stated current NHSCT Cancer Health and Well-Being (HWB) events did not meet the information needs of people with advanced cancer. Scoping identified:

- Breast Care Cancer CNS - 117 patients with advanced cancer on caseload - no access to online HWB resources. This was only one cancer type
- No regional HWB resources for advanced cancer, limited nationally
- Cancer strategy 2022 (DOH) states all cancer patients should have targeted information addressing holistic needs

"I've no HWB resource to give to my palliative patients" CNS

"It felt like closure for 'them' - nothing was closing for me" SU with Advanced Cancer

What we did:

- Established SU focus group
- Presentations developed
- Videos produced with professionals using Teams

Liaison with

- Corporate Comms – media support
- Cancer Services – use of platform

Developed

- Feedback mechanisms
- Promotional material

Advanced Cancer Toolkit

SU Focus Group

- Formed through HWB event feedback, CNS and Macmillan networks
- Hybrid model - online/ F2F
- Created title, introduction and topics
- Discussed language/ barriers eg word palliative, location of resource
- Reviewed presentations and promotional material
- Participated in launch

"Patients see things that staff don't see. We understand how we like to be spoken to and we are the experts of our own condition."
Helen McGarvey, SU
speaking at Toolkit Launch Event

Next steps:

- Promote resource
- New presentations
- Considering podcasts
- SU event to identify further gaps

WATCH VIDEO examples

Local Services section

Located on NHSCT website under Cancer Services
For more information contact:
palliativecare.events@northerntrust.hscni.net

NEW

Currently under development as a regional resource

ellenor
hospice care in your home or ours

Tackling frailty in care homes through exercise

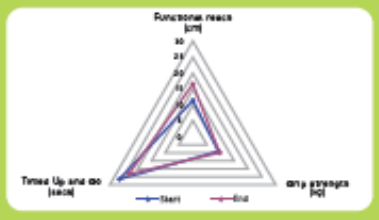
Frailty doesn't have to be a given in later life. Regular exercise is a powerful tool that can help combat its effects.

"THE RESIDENTS ACTIVELY LOOK FORWARD TO THE SESSIONS AND OFTEN ASK TO MAKE SURE ALEX IS STILL COMING IN"
– Care home staff –

"THIS IS MY FAVOURITE THING TO DO IN THE WEEK. IT'S HELPED ME USE MY SHOULDER AGAIN WHICH I HAVEN'T BEEN ABLE TO DO FOR AGES"
– Care home resident –

"IT HAS BEEN GREAT TO SEE THE PROGRESSION OF SOME RESIDENTS THROUGHOUT THIS PROJECT. I REALLY FEEL IT HAS MADE A DIFFERENCE TO SOME, BOTH PHYSICALLY AND MENTALLY"
– Exercise prescriber –

186 unique individuals participated in exercise groups



Frailty Project – August 2024
Comparison of start and end readings for patients attending Seated Exercise group in Care Home setting

Improvement in Mobility Speed (average) **12%**

Improvement in Balance (average) **47%**

Improvement in Grip Strength (average) **7%**

Largest reduction in "Timed Up and Go" score **11.6secs**

Biggest increase in "Functional Reach" ability **17cm**

Largest increase in "Grip Strength" **3.4kg**

ellenor has been delivering seated exercise groups inside care homes across Kent, and seeing improvements in strength, mobility and balance.

Additionally, residents have also reported improvements in wellbeing, and staff have equally noticed a difference in the participants' quality of life.

The exercise groups have not only promoted independence, but improved mental wellbeing and fostered a sense of community.

With even a small amount of regular exercise, older adults can not only reduce the chance of frailty progression, but indeed reverse it.

So let's prioritise movement and empower residents to live stronger, healthier, and more fulfilling lives.

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EXERCISE: THE KEY TO FIGHTING FRAILTY!

Kirby Laing Foundation · hospice UK · P.W. Physiotherapy

Singing for Lung Health Group Intervention:
An Occupational Therapy Led Pilot In a Community Palliative Care Setting

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Our Lady's Hospice & Care Services, Harold's Cross, Dublin.

Background

'Singing for Lung Health' (SFLH) is an emerging evidence-based group intervention with the goal of producing song together whilst supporting individuals with breathlessness to acquire self-management skills. It has been shown to improve quality of life, ability to self-manage breathlessness and cost-effectiveness, within respiratory cohorts such as Chronic Obstructive Pulmonary Disorder and Idiopathic Pulmonary Fibrosis. Occupational Therapy plays a key role in palliative rehabilitation working on a person's goals to optimise function and quality of life in the context of complex symptom management. Many patients under the Community Palliative Care Team (CPCT) have refractory breathlessness and are referred to Occupational Therapy for symptom control.

Objective

To evaluate an 8-week Occupational Therapy pilot of a 'SFLH' group within a community palliative care service to determine the impact of 'SFLH' on perceived breathlessness, quality of life, anxiety and depression.

Method

An 8-week pilot of the 'SFLH' group was facilitated, by a Senior Occupational Therapist with training in SFLH. Purposive sampling identified participants who met the criteria within the CPCT service, and they were provided with a participant information leaflet. Outcome measures were completed at weeks 1 and 8, including modified BORG Breathlessness Scale; Hospital Anxiety and Depression Scale (HADS) and EQ-5D-5L. A questionnaire and focus group were completed at week 8 to gather participant feedback.

Results

Modified BORG Pre Scores (median: 3)	Post Score (median: 3)
1. 0.5	1. 1
2. 1	2. 1
3. 3	3. 7
4. 5	4. 8
5. 3	5. 3

HADS Pre (median: 4;6)	Post (median: 8;9)
1. Anxiety = 1 Depression =1	1.Anxiety= 1 Depression= 1
2. Anxiety= 3 Depression= 5	2. Anxiety= 7 Depression= 9
3. Anxiety= 4 Depression= 9	3. Anxiety= 9 Depression=10
4. Anxiety= 8 Depression=7	4. Anxiety=10 Depression= 10
5. Anxiety =7 Depression=6	5. Anxiety = 8 Depression= 8

EQ-5D-5L Pre (median: 70)	Post (median: 40)
1. Overall Health = 85	1. Overall Health = 100
2. Overall Health = 90	2. Overall Health = 50
3. Overall Health = 25	3. Overall Health = 30
4. Overall Health = 70	4. Overall Health = 30
5. Overall Health = 50	5. Overall Health = 40

Participant Feedback

I felt terrible coming in to the group today but I feel better leaving.

You feel better – forget you can't breathe.

I'm going to miss it on a Wednesday evening. It made a huge difference to my breathing.

Conclusion

SFLH as an Occupational Therapy, palliative rehabilitation intervention offers patients with breathlessness a novel method of symptom management and peer support.

Although quantitative findings indicated an overall deterioration in scores which can be expected with a palliative cohort, the qualitative feedback indicated that **'SFLH' was a positive intervention for participants who described improved mood, breathlessness management and improved coping.** The 'SFLH' group offered peer support, meaningful engagement and a sense of control over their breathlessness.

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Acknowledgements

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Enhancing Occupational Engagement through improved Breathlessness Mastery

Julie Donohoe MSc, BSc OT[1]

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Background

Breathlessness can impact patients' quality of life, being one of the most common and burdensome symptoms affecting those with life-limiting diseases (Simon et al, 2024). Non-pharmacological interventions for breathlessness management should be trialled as first line approach, after the underlying condition has been optimised (Simon et al, 2024).

Case Presentation: A lady in her 70s with a diagnosis of pulmonary hypertension and heart failure, with symptoms of breathlessness, panic, fatigue and reduced engagement in daily routine, attended the BREATHE programme in her local hospice.

Intervention: BREATHE is an occupational therapy led breathlessness management programme, based on the Cambridge Intervention Breathlessness Service "Breathing, Thinking, Functioning" model (Booth, 2013). It is a group based programme, of four 60 minute sessions, spread over four weeks.

Outcome: The patient reported increased confidence managing her breathlessness and felt less anxious. She decided work on a goal of returning to painting, a much loved hobby. She bought new paints and spent some afternoons at home doing water colour painting. She spoke of painting as *"an adventure"* and it was relaxing and a distraction from symptoms. It became a source of chat for her and her friends

Conclusion

By learning strategies to improve her breathlessness mastery, the patient was more confident and motivated to engage in occupational based goals, demonstrating how a rehabilitative palliative care approach can support meaningful engagement.

Contribution to Practice

This case study demonstrates the impact adopting a rehabilitate palliative care approach to breathlessness mastery can have on meaningful engagement in valued occupations. This approach facilitated by the occupational therapist, compliments the work of the wider multidisciplinary team in supporting a patient experiencing breathlessness.

References:
Booth, S. (2013). Cambridge Breathlessness Intervention Service (CBIS). *Progress in Palliative Care*, 21(4), 224–228. https://doi.org/10.1179/1743291X13Y.0000000058
Simon, S. T., Higginson, I. J., Bausewein, C., Jolley, C. J., Bajwah, S., Maddocks, M., Wilharm, C., Oluyase, A. O.,Pralong, A. & BETTER-B Consortium. (2024). Practice review: Pharmacological management of severe chronic breathlessness in adults with advanced life-limiting diseases. *Palliative Medicine*, 38(10), 1079-1087.

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Addressing Peripheral Neuropathy to Support Occupational Engagement

Julie Donohoe [1] & Sarah Delaney [1]

St. Francis Hospice

Background

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

Case Presentation

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

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

Management and Outcomes

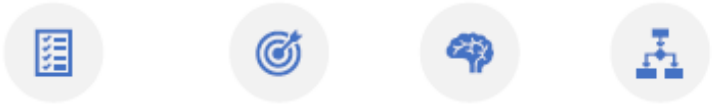
Tactile stimulation interventions (Quintal et al., 2021) were carried out with patient consent. This involved the patient immersing each hand in a basin of uncooked rice and searching for items within. Pain and numbness in each hand were scored, pre and post intervention on a visual analogue scale (Figure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

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

Figure 1: Example of outcomes scores

Discussion and Learning Points

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



Conclusion

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

Contribution of Practice and Originality

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

References:
Alkandari, M., & Hollywood, A. (2023). People's experiences living with peripheral neuropathy: a qualitative study. *Frontiers in Pain Research*, 4, 1182405.
Klein, I., & Lehmann, H. C. (2021). Pathomechanisms of paclitaxel-induced peripheral neuropathy. *Toxics*, 9(10), 229.
Montagnini, M., Javier, N. M., & Mitchinson, A. (2020). The role of rehabilitation in patients receiving hospice and palliative care. *Rehabilitation Oncology*, 38(1), 9-21.
Quintal, I., Carrier, A., Packham, T., Bourbonnais, D., & Dyer, J. O. (2021). Tactile stimulation programs in patients with hand dysesthesia after a peripheral nerve injury: A systematic review. *Journal of Hand Therapy*, 34(1), 3-17.
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Creating opportunities for meaningful engagement – a rehabilitative palliative care approach

Julie Donohoe MSc , BSc[1] , Beth Carr BSc [2]

St. Francis Hospice

Background

The PEER programme (Palliative, Enablement, Exercise and Rehabilitation) aims to improve quality of life for people with life-limiting conditions by adopting a palliative rehabilitation approach to their care. PEER is a group programme, jointly facilitated in the hospice out-patient and day service by occupational therapy and physiotherapy teams. By participating in activity and discussing functional performance challenges it helps patients to maximise their capacity to the best of their ability, thus promoting engagement (WHO, 2023).

Methodology

A plan, do, study, act (PDSA) cycle was completed to guide a quality improvement project incorporating feedback from group participants. Participants and facilitators agreed on a move from lecture based education sessions to a more interactive and dynamic programme. This resulted in creating opportunities for meaningful engagement based on the participants interests and symptom management related to daily routine.

Outcomes

Meaningful engagement such as baking, planting, darts, boules, cycling, football, art and crafts was included in the group. This allows for self-management strategies, discussed in the group, to be applied to occupation and exercise in a meaningful way.

Patient feedback shows this impact of this focus:

"I'm retaking bus journeys and Luas trips again"

"I enjoyed the games – memories came back of playing golf and darts in the past"

"I rejoined indoor bowling and am more likely to try to do things"

Contribution to Practice

By aligning closely with the ethos of rehabilitative palliative care, the PEER programme facilitates a focus not on "what's the matter" (fatigue, pain, loss of function) to "what matters to you" (playing darts, being able to plant pots for my garden, baking a cake for family) (Tiberini & Hayes, 2024).

Reference:
Tiberini, R., & Hayes, A. (2024). How to adopt a rehabilitative palliative care approach. *Nursing Times*, *120* (7).
World Health Organization. (2023). *Policy brief on integrating rehabilitation into palliative care services* (No. WHO/EURO: 2023-6825-45590-68173). World Health Organization. Regional Office for Europe.

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Integrating Social and Therapeutic Horticulture (STH) into Rehabilitative Palliative Care

Northern Ireland Hospice

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"It is lovely to have something that is alive to look after. Just being around the plants makes me feel less stressed." Occupational Therapy patient

Background

Social and therapeutic horticulture (STH) has emerged as a valuable intervention in palliative care (Pilgrem, 2023), offering a holistic approach to rehabilitation that addresses the physical, emotional, and social needs of patients (Pilgrem, 2018). STH promotes opportunities for sensory stimulation, gentle physical exercise, and creative expression (Trellis, 2025). These activities can help to alleviate common symptoms such as pain, fatigue, and breathlessness, while also providing a calming and restorative environment. However, there is very little literature available to substantiate the impact of STH in the context of rehabilitative palliative care.

Objectives

The aim of this study is to explore the impact of STH on patient distress levels in a rehabilitative palliative care setting. Distress is defined as physical challenges, pain, functional limitations and psychological disturbances. In addition, to ascertain if STH supports best practice in rehabilitative palliative care (Hospice UK, 2022).

Method

The occupational therapist facilitated various STH sessions in the in-patient unit including flower arranging, creating gravel gardens, planting watercress, peas and sunflower seeds, pressed flower crafts and wreath making. Sessions lasted between 30-90 minutes. Adherence to infection prevention and control measures (Hospice UK, 2020; STHH PC, 2022) ensured safe practice. All activities were graded to allow maximum participation (Health and care professions council, 2023). Sessions took place in patients' rooms, the garden and rehabilitation suite. Using the Distress Thermometer (DT), participants rated their perceived distress level before and after each session. In addition, patients's subjective experiences were recorded using their exact words.

Results

All the feedback from participants was positive with 94% reporting a reduction in distress levels and 41% reporting zero distress after their STH session. The mean DT score before STH session was 6.4 and after participation the mean DT score reduced to 1.5. Patients verbally reported feeling relaxed, improved mood and de-stressed. In addition, patients reported STH sessions were a good distraction from their ongoing health issues and felt a sense of achievement when looking at what they had created.

Conclusion / Implications for practice

The evaluation shows that STH can improve quality of life and reduce distress levels in palliative patients. STH is a valuable intervention in rehabilitative palliative care settings and meets guidelines for best practice by providing opportunities to interact with others and engage in meaningful activities. STH sessions can be graded and adapted to meet patient functional abilities and carried out in a variety of settings. However, a budget and resources are needed to continue to facilitate sessions.

References and acknowledgements

Northern Ireland Hospice Ltd Company Limited by guarantee incorporated in Northern Ireland and is a charity recognised by the Inland Revenue. Company Registration No: NI 14837 Charity No: NIC 103317

Developing an Occupational Therapy Fatigue Management Clinic in a Specialist Palliative Care Outpatient Service

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Orlaith Martin, Occupational Therapist Manager[1],
[1]Our Lady's Hospice and Care Services, Harold's Cross.

Background

- Fatigue is among the most prevalent and debilitating symptoms experienced by individuals with advanced illness, profoundly impacting daily functioning and quality of life[1].
- 30% of referrals to the Occupational Therapy outpatient specialist palliative care (SPC) service are for fatigue assessment and intervention.
- Non-pharmacological interventions, including symptom self-management education, are central to palliative rehabilitation, enabling individuals to maintain function and engage in meaningful activities despite inevitable disease progression[2].
- While a limited evidence base supports the effectiveness of this approach[3], there is insufficient understanding about the optimal way to deliver Occupational Therapy fatigue management intervention in SPC outpatient services.

Objective

- To develop an Occupational Therapy fatigue management clinic that offers a comprehensive, standardised approach to fatigue assessment and delivers individualised treatment plans for patients accessing the community SPC service.
- To collect data and patient feedback to evaluate the effectiveness of our fatigue management practices and identify the most effective ways to deliver fatigue management interventions for these patients.

Actions and Method

- One morning per week was allocated to fatigue clinic assessment and intervention sessions in the Occupational Therapy outpatient schedule.
- An information leaflet was developed to inform patients about the service and to promote the clinic among referrers (Figure 1).
- The fatigue clinic model was developed. Patients first receive a comprehensive 1:1 assessment with an OT. This includes details of their fatigue history, subjective information about the impact of fatigue on daily life, the Symptom Assessment Scale[4] (fatigue subscale) and the FACIT-Fatigue scale[5] (Figure 2).
- Patients are supported to set individual goals aimed at reducing the impact of fatigue on important daily activities, and an individualised treatment plan is created. This can consist of 1:1 or group intervention sessions, depending on individual needs and preferences. See Figure 2 for interventions offered.

Figure 1. Patient Information Leaflet Developed

Assessment		Intervention
• **Fatigue History:** Onset, duration and pattern of fatigue, types of fatigue experienced, associated/alleviating factors, sleep, medication and treatment history... • **Subjective Ax**: Impact on daily life, important activities, routine... • **PCOC – Symptom Assessment Scale** (SAS) for Fatigue: visual analogue scale. • **The Functional Assessment of Chronic Illness Therapy** (FACIT)- **Fatigue Scale.**	**Person-Centred Goal Setting** → **Individualised Treatment Plan**	• Offered 1:1 or in group setting • Energy and activity monitoring - fatigue diary, overactive/underactive cycle • Education - what is fatigue – validation • Energy conservation/restoration strategies • Activity analysis/modification • Equipment/small aids provision • Environment/ergonomic assessment • Relaxation, rest, stress & anxiety management

Figure 2. Fatigue Clinic Model, Assessments and Interventions Offered

Results and Outcomes

- As part of this initiative, two fatigue management groups, with nine participants were delivered in the SPC outpatient department. The majority of participants were living with cancer and were significantly impacted by fatigue at the time of participation.
- Post-intervention, all participants indicated a reduction in the impact of fatigue on daily functioning, measured by the FACIT-Fatigue scale.
- Feedback was highly positive, with participants reporting increased understanding of fatigue, improved self-management skills, and valuable peer support.
- While data from individual sessions have not yet been analysed, data collection is ongoing, for future evaluation.

Reflection and Future Plans

- This clinic has demonstrated early effectiveness in reducing the impact of fatigue on daily life and will therefore continue to be promoted, implemented, evaluated, and further developed within the community SPC service.
- It is important to include and collect data from those with conditions other than cancer, to assess intervention effectiveness and identify unique fatigue management needs, ensuring the service is optimally tailored for all patient cohorts receiving specialist palliative care.
- The rehabilitative benefits of this intervention in preserving important daily function, meaningful activity participation and quality of life as illnesses progress are likely to be most effective when initiated early, before individuals are significantly affected by fatigue. Identifying patients who could benefit from this programme at the time of referral to SPC community services, and developing the necessary resources for timely implementation, is an important future goal for this service.

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Acknowledgements:
We would like express our gratitude to the patients who have participated and provided feedback on this service to date and to our MDT colleagues for their ongoing collaboration and support.

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Exploring The Role Of Occupational Therapy Practice in a Specialised Inpatient Unit

Sarah Delaney[1], Elaine Walsh[1]

St. Francis Hospice

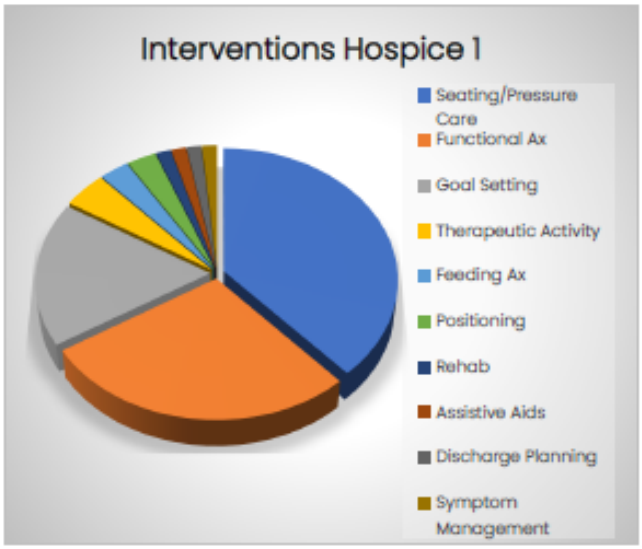
Background

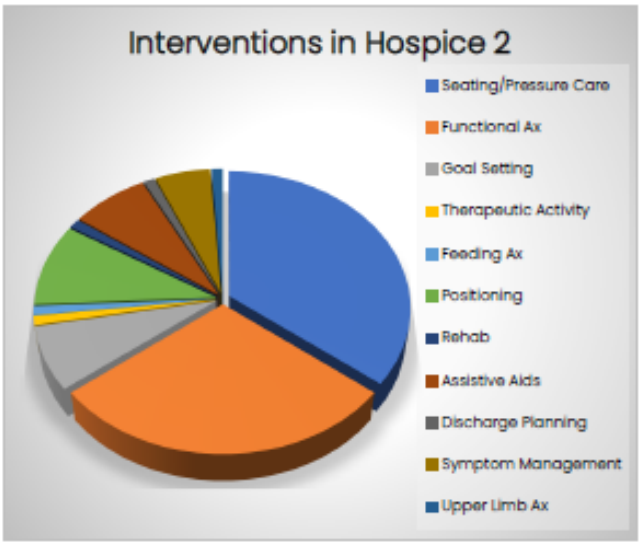
OT plays a valuable and distinct role in palliative care by empowering patients to lead fulfilling lives within the restrictions of their illness (Eva and Morgan, 2018). There is an emerging evidence base about the role of OT in palliative care but little is known about the range of interventions in a specialist palliative care inpatient unit (IPU)

Aim: To profile patients receiving OT by describing the types of interventions, diagnosis types, and demographic details.

Methods: A retrospective healthcare records review on 100 charts was completed over eight weeks on two specialised inpatient hospice sites.

Results





Participants	Diagnosis types	Referral Source	Age profile
100 (both sites) 54 Males 46 Females	83 Cancer 13 non-malignant 4 Neuro	46 Home 24 Beaumont Hospital 14 Mater Hospital 4 Connolly Hospital 5 Private Hospital 7 Other	Mean age 76.24 (H1) Mean age 66.9 (H2)

Seating and functional assessments were the most frequently completed interventions across both sites (51%). Thus, highlighting that OT'S adopt a functional approach to practice in a SPC IPU. Provision of assistive aids (12%), symptom management (6%) and therapeutic activity (4%) were completed to a lesser extent. There was little evidence of palliative rehabilitation on both sites. (2%)

Conclusion

The data gathered from this study will assist to improve the development and progression of pathways for occupational therapy interventions in SPC IPU's nationally. It will also provide greater insight on the range of OT interventions completed in SPC IPU, including areas of service development.

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

Eva, G., & Morgan, D. (2018). Mapping the scope of occupational therapy practice in palliative care: A European Association for Palliative Care cross-sectional survey. *Palliat Med*,32(5):960-968

Development of a Physiotherapy-led Rehabilitative Program to Manage Dyspnoea in Advanced Illness in a Palliative Care Setting

Elaine Murray, Senior Physiotherapist and Jean Ryan, Senior Physiotherapist

Background

Exercise has been proven to be safe and feasible for people living with advanced illness[1]. It has the potential to yield benefits in alleviation of distressing symptoms and improve quality of life[1-3]. The benefits of an interdisciplinary approach have been shown to be effective in symptom management in patients receiving palliative care[2,4]. Standard in practice in Milford had been to review patients on an individual basis. However, knowing the benefit of group exercise, establishing this service became a priority.

Objectives

- To develop a physiotherapy-led program incorporating supervised group exercise, education and relaxation with input from other disciplines as appropriate.
- Aim for completion rate of >70%
- Produce a service that is satisfactory for service users, as assessed through satisfaction questionnaire.

Method

Participants were identified via triage and referral through respiratory services. Inclusion criteria consisted of; individuals already under the specialist palliative care service, experiencing refractory dyspnoea and with an Australia-modified Karnofsky Performance Status (AKPS) score of greater than 50. Initial assessment was completed on an individual basis with a senior physiotherapist to deem suitability and gather baseline information and outcomes. Outcome measures included Modified Medical Research Council Dyspnoea Scale, 6 Minute Walk Test, 60 Second Sit to Stand and the Dyspnea 12 Questionnaire. Supervised exercise and education occurred weekly for a maximum of 12 weeks. A combination of aerobic, resistance, balance and flexibility exercise were incorporated. Evidenced based advice and practical information was provided to manage breathlessness by physiotherapy and occupational therapy as appropriate. Group relaxation techniques were performed to conclude each session. Onward referral to other disciplines as appropriate was carried out.

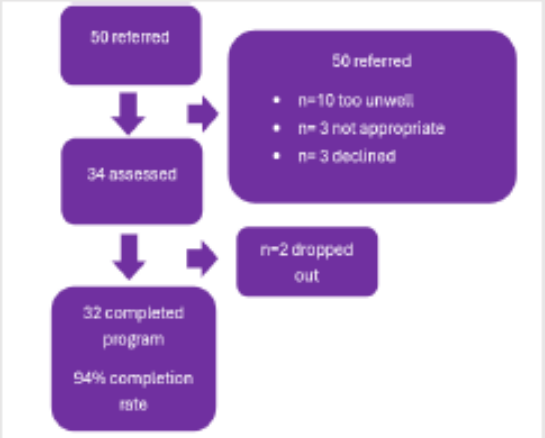
Results

Over a 12-month period, 50 referrals were received to the program and triaged. 34 were assessed and 32 went on to complete the full cycle (see Figure 1). Most common conditions were lung cancer (n=13, 40.6%), COPD (n=11, 34.40%) and pulmonary fibrosis (n=8, 25%).

- **Feedback questionnaire demonstrated that participants found the program beneficial and improved function.**
- **75% reported the program helped them significantly improve their ability to self-manage dyspnoea.**
- **91% participants reported feeling supported by the group and physiotherapists facilitating the program.**

"Just to say, you do great work and a job much appreciated by those attending. Team are so clued in to anyone struggling with breath"
Participant

Figure 1



Conclusion/Implications for Practice

A physiotherapy-led group exercise and education program to manage dyspnoea in advanced illness was safe and subjectively improved participants ability to self manage their dyspnea. Further scope remains to increase service frequency to twice weekly sessions as service permits. Improved regular interdisciplinary inclusion in the program to provide education needs to be further developed to enhance holistic care. Further research needs to be undertaken on the benefits of this service as there is limited comparative services available in the Mid West.

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A direct 6-month comparison of referral rates, patterns and response times pre and post the establishment of an onsite speech and language therapy service in a specialist palliative care in-patient unit. MDT and family reflections.

Claire Parkes, Speech and Language Therapy Manager, Valerie Flood, Senior Speech and Language Therapist

Our Lady's Hospice & Care Services

Harold's Cross Blackrock Wicklow

Respite Rehabilitation Reassurance

Background

There is a national inequity of access to speech and language therapy (SLT), within specialist palliative care (SPC). Out of 14 SPC in-patient units, 6 have no SLT service. SPC units with SLT have inadequate workforce resources, planning and sustainability. As a result, many communication and/or swallowing difficulties and/or related quality of life issues, which present as a direct consequence of the illness, or as a burden of treatment, go undetected by the SPC multidisciplinary team.

Objectives

Two key objectives were to a) identify the impact of having an onsite SLT with MDT attendance on referral patterns within a 12-bed SPC unit b) ascertain the impact of having an onsite SLT on MDT functioning, patient symptom management and quality of life.

Method

Within a 12-bed SPC unit, prior to June 2024, SLT referrals were accepted by an off-site SLT. Referral rates, response times and referral patterns were prospectively compared for the 6 months before and after an onsite SLT service was established. Qualitative data on the benefits of having SLT as a core member of the SPC team were provided by the MDT, patient and families

Results

Following commencement of the part time onsite SLT service, referral rates rose by 452% over a 6-month period. The number of patients discharged or 'died before seen' fell from 47% to 11%. Prioritisation Key Performance Indicators were achieved in 100% of patients seen by the onsite SLT.

SLT Referrals

Died or Discharged Before Seen

Referrals generated following SLT attendance at weekly MDT meetings, accounted for 29% of referrals in the 6 months following the onsite SLT service.

Pattern of Referrals

- Referrals generated at weekly MDT meetings
- Referrals generated outside of weekly MDT meetings

In the 6 months preceding the establishment of an onsite SLT service, 100% of referrals were for patients admitted for end of life care (EOLC). By the end of the following 6 months, 90% of referrals were patients admitted for EOLC, 5% were admitted for symptom control and 5% were respite admissions. Malignant (77%/78%) versus non-malignant (23%/22%) breakdown of referrals remained largely unchanged.

Qualitative Feedback

'SLT bring a unique and often overlooked expertise to the multidisciplinary team. For the MDT to act in tune, they are a much valued voice for the harmonious choir' *Dr Paul Gregan, Consultant in Palliative Medicine*

'A SLT in hospice care doesn't just help people speak—they help them be heard, understood, and connected, even when words begin to fade.' *Princy Praveen, CNM II*

'Having you among us is a benefit for all of us (staff and patients), because you give us the peace of mind in relation with our patients IDDSI food levels. Your daily advice and tips/recommendations about what patients can eat and what it is safe for them makes us really happy to have you on the site. Thanks a million!' *Samantha Webster, Catering Services*

'The SLT educated the whole team and family on how to facilitate good communication and care. Our SLT drove the team in identifying what needed to change, and did this without delay and she understood the needs and that time was important to all involved.' *Patient's spouse*

Discussion

SLTs uniquely understand communication and swallowing disorders across the lifespan. There is a growing awareness of the benefits of having SLTs as core members of the SPC team, and the risks of not having SLTs on the team. Without SLTs as core SPC MDT members, the timely identification of persons requiring SLT input is not possible. Without an adequately resourced and sustainable SLT workforce, palliative rehabilitation, symptom management and quality of life interventions for persons with communication and/or swallowing disorders cannot be optimised.

Recommendations

- Provide equity and quality of access to SLT for persons with communication and/or swallowing impairment, within in-patient and community-based adult and paediatric specialist palliative care services, across the country (IASLT 2025).
- Engage with all stakeholders including service users, to enhance SLT education, and to build the evidence base for the benefits of SLT interventions in specialist palliative care (IASLT 2025)

References

Department of Health (2024) The National Adult Palliative Care Policy

The Irish Association of Speech and Language Therapists (2025) Position Paper On The Role of Speech and Language Therapists in Specialist Palliative Care

DEVELOPING AND DELIVERING A FATIGUE, ANXIETY AND BREATHLESSNESS PROGRAMME (FAB):

An Interdisciplinary Service Innovation for Breathlessness Management in Specialist Palliative Care

AUTHORS: Catherine Carney, Margaret Fitzgibbon, Miriam Morris, Dr. Alison Cran, Joan Boult, Donna Lynott.

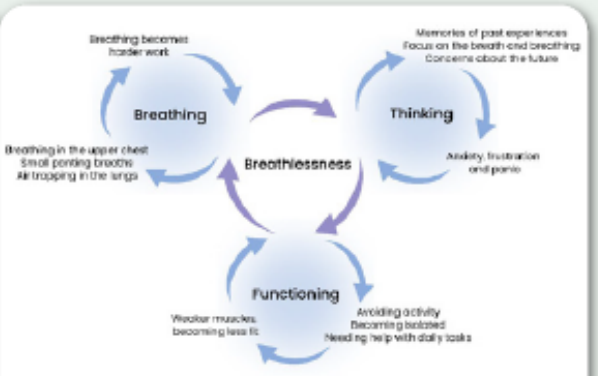
INTRODUCTION:

At national levels, incidence and prevalence data is not available for respiratory disease as a group. Since the opening of the Mayo Hospice 4 years ago there has been a steady increase of referrals for the complex breathless patient.

BACKGROUND:

A need was identified to link respiratory patients with palliative care in the hospice setting earlier in their disease trajectory. Although locally there is a pulmonary rehab running in Mayo there is a cohort of patients who would not be suitable for this but require input to manage their breathlessness. The Fatigue, Anxiety, and Breathlessness programme (FAB) was developed in response to an identified service gap for individuals experiencing complex breathlessness with associated symptoms and introduce them to the Mayo Hospice and palliative services available to them.

FAB was designed as a non-pharmacological, interdisciplinary evidence-based intervention to improve symptom management, quality of life and provide patients and carers access to coordinated and holistic support based on the well establish Breathing Thinking and Functioning model developed by Dr. Sara Booth at the Cambridge Breathlessness Intervention service.



Reproduced with permission of the Cambridge Breathlessness Intervention Service.

OBJECTIVES:

To design, implement and evaluate a new interdisciplinary palliative care programme that delivers coordinated, person-centred, evidence-based breathlessness interventions.

PLANNING AND DEVELOPING:

FAB was developed and delivered by nursing, occupational therapy and physiotherapy in Mayo hospice outpatient setting.

Step 1: Collaborative planning meetings OT Physio and Nursing on how to implement and develop this programme for roll out

Step 2: Presentation to stakeholders creating inter-service communication with community and hospital respiratory teams supported the creation of referral pathways for the appropriate patient

Step 3: Design of the triple assessment tool – an interdisciplinary assessment tool. Nursing Occupational Therapist and Physiotherapist collaborated to create a unified assessment tool that streamlines pre-assessment for FAB participants. This has allowed holistic assessment without duplication for the participant.

Step 4: Researched and evaluated the best outcome measures to use to get information for evaluation of the programme. Creation of appropriate consent form for participants of the programme in liaison with the hospices research manager and Data protection consultant, for compliance with GDPR.

Step 5: Designed over six weeks, with four two-hour clinical sessions incorporating education, relaxation, exercise, peer support and carer involvement.

Step 6: Roll out of 6 weeks programme, including initial assessments, 4-week FAB programme, outcomes measures and evaluation.

PARTICIPANT FEEDBACK:

Excellent

Very, very supportive

It was just right.

CARER FEEDBACK:

- ✔ *Improvements in their loved one's coping and confidence.*
- ✔ *Identified needs relating to carer burden and lack of support.*

FAB TEAM FEEDBACK:

Growth in participants' confidence, willingness to share personal experiences.

Social connection and peer support evident within the group.

Individual ability levels varied, and one-to-one support was provided where needed.

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE:

The FAB pilot represents a successful model of interdisciplinary service development in palliative care, responding to a local service need. The collaborative approach supported delivery of efficient and holistic person-centred care. Ongoing data collection is required and planned to further evaluate future programmes.

Challenges: Participant illness, the impact of travel distances to Mayo Hospice on participants fatigue, highlighting the need for flexible delivery models.

Future considerations include expanding referral pathways, provision of additional carer support and exploring community-based model to improve access to participants who identify distance as a barrier to attending and continuing to run the current 6-week FAB programme and ongoing evaluations, creating changes as required.

References:

- Spathis A, Booth S, Moffat C, Hurst R, Ryan R, Chin C, et al. The Breathing, Thinking, Functioning clinical model: a proposal to facilitate evidence-based breathlessness management in chronic respiratory disease. npj Primary Care Respiratory Medicine. 2017;27(1):27
- Booth Sara et al (2011). Non-pharmacological intervention in breathless. Current option in support and palliative care. 5:77-86

Acknowledgements: A sincere thank you to our FAB participants who shared their experiences and feedback on the programme.

To explore the experiences of patients attending pulmonary rehabilitation in a specialist palliative care setting

Sinead Coyle , Fiona Cahill, Physiotherapy Department, St Francis Hospice Dublin

St. Francis Hospice

INTRODUCTION

Background

Specialist palliative care (SPC) has evolved to include non-malignant diseases, including end-stage respiratory conditions. The symptom burden of such conditions include breathlessness, reduced function and reduced quality of life. Pulmonary rehabilitation (PR) is supported in the literature to target these symptoms. For this reason, it has become a component of palliative rehabilitation, irrespective of the advanced stage of illness.

Study Rationale

Patients who have completed palliative rehabilitation programmes have reported a very positive experience despite the trajectory of their illness but to our knowledge, there are no studies exploring the patient experience of attending PR in an SPC setting.

Aim

To explore patients' experiences of attending pulmonary rehabilitation (Exhale) in a palliative care setting.

METHODOLOGY

Design

- Qualitative
- Semi-structured interviews
- Analysis - Inductive Thematic Analysis
- Ethical approval obtained from St Francis Hospice Research Ethics committee.

Setting

In response to the COVID-19 pandemic, the delivery of this programme (Exhale) transitioned from an in-person class to an online format during the recruitment period.

Recruitment & Participants

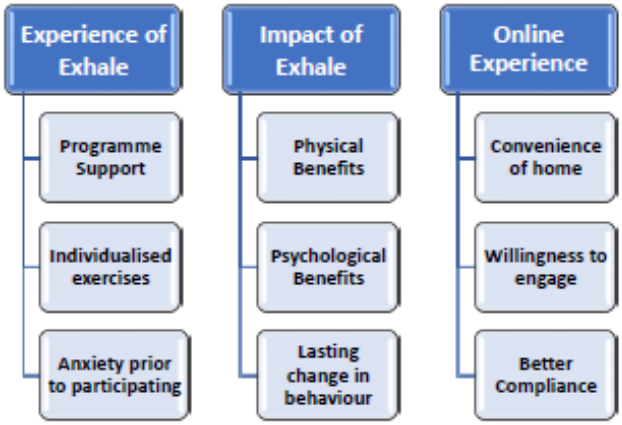
Patients who completed Exhale from March 2021 – June 2021

Inclusion Criteria	Exclusion Criteria
Completed PR between March 2021 – June 2021	Not proficient in the English language
Consented to participate	Cognitive impairment

RESULTS

- 22 participants completed Exhale
- 8/22 met the criteria for the focus group
- 6 consented to interview

The focus groups yielded 3 main themes and subthemes:



Experience of Exhale

"I was a bit apprehensive, but now I'm confident"

Feedback was very positive and reflective of participants overall experience of participating in Exhale

Impact of Exhale

"I wouldn't be as good as I am today without them"

This theme reflects both the physical and psychological benefits of Exhale, and a motivation to continue.

Online Experience

"I don't think I'd have done them at all if I had to be going in"

This was an unanticipated finding. Participants found the online platform convenient and less stressful.

DISCUSSION & IMPLICATIONS

- PR in SPC settings improves function, dyspnoea and consequently quality of life, despite the trajectory of the illness.
- Physical functional remains one of the most important determinates of quality of life for individuals under palliative care services.
- Achievable goals help to sustain the adherence and engagement in exercise.
- Virtual PR is a viable option in SPC and should be further explored.

Speech and Language Therapy and Occupational Therapy Working in Partnership to Maximise Quality of Life for Patients with Rare, Complex, Neurodegenerative Disorders

Claire Collins, Senior Speech & Language Therapist[1]
Megan Walls, Senior Occupational Therapist[1]
[1]Our Lady's Hospice and Care Services

Background

- A female patient with a rare, complex neurodegenerative disorder was admitted to the specialist palliative care inpatient unit.
- Progressive anarthria and deteriorating upper limb function impacted her ability to communicate verbally and nonverbally using mainstream technology, and restricted her access to social media and online entertainment.
- This led to a breakdown in communication between the patient and healthcare providers, limiting her ability to engage in daily activities and healthcare decisions, and resulting in increased vulnerability, social isolation, and distress.
- A switch access, assistive technology device and moulded seating system had been previously provided however were not being used at home.
- Limited Occupational Therapy (OT) and no Speech and Language Therapy (SLT) outpatient service was available in the organisation.

Objectives and Method

- This is a case reflection demonstrating collaborative practice between OT and SLT in specialist palliative care to optimise the use of assistive technology for communication and access to environmental controls. Verbal consent was obtained to present this case.
- The key objectives were to explore existing barriers and seek innovative solutions to optimise and integrate the patient's seating, positioning and technology access and enhance competence and confidence using an assistive technology device.
- The SLT and OT teams worked together onsite, and in the patient's home, to integrate and support engagement with her assistive technology device, specialised seating system and environmental controls.
- Collaborative engagement also occurred between the SLT, OT, the national assistive technology and specialised seating service and relevant community teams.
- Education was provided to the patient, family, inpatient and community palliative care teams to ensure consistent set up and use of the assistive technology device.

Results and Outcomes

- The patient's communication function, environmental access and moulded seating system were optimised.
- These interventions facilitated communication of daily needs, improved postural support, comfort and safety, facilitated advanced care planning, enabled participation in complex symptom management, supported social engagement, and reduced distress.

Therapy Outcome Measures for Rehabilitation Professionals[1] – (Clinician Rated)

Augmentative and Alternative Communication	Initial	Post – 7 Months
Activity-Communication	1 Limited functional communication	4 Functional communication – broad range of individuals
Participation	1 Low self-confidence/poor self-esteem/limited social integration/socially isolated	3 Makes decisions and has control over some aspects of life
Well-being	1 Severe levels of distress	3 Moderate levels of distress

Feedback

'[This] has been a game-changer for the patient. It's taken perseverance and patience to get her to use it but without it things would be so much more difficult... The patient has challenged us, but it's also been wonderful to see what we could rise to'.
(Consultant in Palliative Medicine)

'The GridPad has quite literally given the patient a voice. It allows her to express her needs, emotions and preferences, fostering a sense of autonomy and reducing frustration. By facilitating interaction with nursing staff, it enhances her quality of care and helps build meaningful connections, improving her overall well-being'.
(Clinical Nurse Manager, IPU)

How much has the Grid Pad impacted your ability to communicate with our team?
"A lot" (Patient)

'Most importantly [the Gridpad] made it immeasurably easier for [her] to continue to express her personality and unique character throughout her illness journey'.
(Clinical Neuropsychologist)

Implications for Practice

- This case demonstrates the value of establishing specialist palliative care OT and SLT outpatient services and how these teams work together to support seamless transitions of care across inpatient and outpatient settings for patients with complex needs associated with life-limiting illnesses.
- In alignment with the National Adult Palliative Care Policy[2] and Sláintecare[3] it is important to develop organisational structures and a skilled interdisciplinary workforce to deliver palliative rehabilitation in the right place, at the right time.

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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.

References:

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Inter disciplinary education to improve clinical decision making regarding nutrition support, on a palliative care ward

(Ann McSorley Specialist Dietitian & Kylah Plant, Nutrition Student)

Western Health and Social Care Trust

Nutrition support is part of holistic palliative care, since advanced disease affects appetite and weight loss is common (1). However, despite recommendations, health care professionals (HCPs) report a lack of confidence with clinical decision making regarding nutrition in palliative care (2). As a result the nutrition and dietetic department observed an increasing referral rate trend.

Aims

To introduce a standard language to describe the overarching nutritional goals of care so that HCPs can implement the appropriate nutrition plan. It is hoped with service improvement initiatives and ongoing education that HCPs confidence will increase to 80% and referrals for Dietetic assessments will reduce by 50% by April 2026.

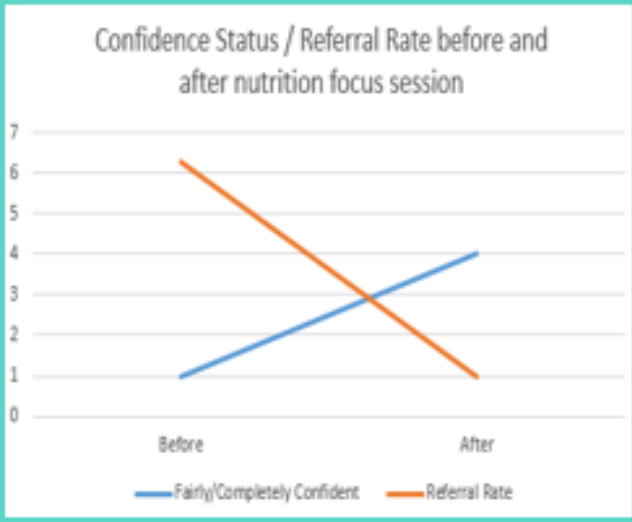
Explore the role of nutrition within different disciplines

Before & after questionnaires concerning IDTs to collate baseline knowledge of nutritional goal planning

Host an interactive education session regarding nutritional needs in palliative care & the importance of nutritional goal planning

Results

- Almost 90% lacked confidence in providing nutritional guidance
- 75% of HCPs expressed a desire for further training
- 50% of the HCPs felt more confident after nutrition teaching session
- 84% reduction in referral 6 months after training



Next steps

1. Disseminate the approved nutrient dense resource
2. Implement smaller plates
3. Display nutrition education posters in the palliative care ward
4. Link nationally to discuss nutritional screening tools in palliative care

References
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Physiotherapy in a Specialist Palliative Care Inpatient Unit – What do we do?

Fiona Cahill, Clinical Specialist Physiotherapist, Lisa McGirr, Physiotherapy Manager, St Francis Hospice,
Dr Ailish Malone, Senior Lecturer School of Physiotherapy, Royal College of Surgeons Ireland

St. Francis Hospice

INTRODUCTION

Background

Physiotherapy and rehabilitative practice are integral components of the services provided on the inpatient units (IPU) of St Francis Hospice.

Many national and international publications recognise the importance of a palliative rehabilitation approach, enabling patients to live as independently as possible for as long as possible.

The role of physiotherapists working in specialist palliative care includes, but is not limited to:

- Helping patients maintain their independence
- Advice on breathlessness management
- Fatigue Management
- Balance and falls rehab
- Psychosocial support through therapeutic movement

Aim

The goal of this study is to describe the profile of patients admitted to the IPU and detail the physiotherapy interventions provided to them

Methodology

- A 3-month prospective healthcare record review
- Baseline demographic and disease profile information was collected for all patients admitted to the IPU.
- A structured template was developed and implemented to categorise physiotherapy interventions by type, location, and duration of treatment.

Physiotherapy intervention by type:

Assessment	Therapeutic Rehab	Respiratory Treatments
Functional Rehab	Patient declined treatment	Medically unfit for treatment

- Instances where physiotherapy was not provided due to resource limitations were also recorded.
- The data was used to profile of IPU patients and analysis of physiotherapy treatment categories.

RESULTS

Demographics

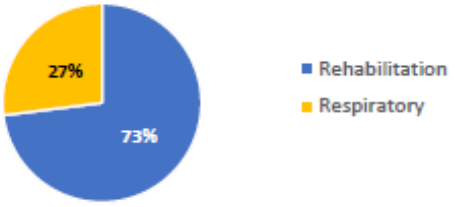
- 157 patients were included in the study
- Advanced cancer accounted for 85% of all admissions
- Lung cancer was the most prevalent cancer
- Median LOS was 10 days (range 1-77 days)

Physiotherapy Input

Overall, 64% of patients assessed by a physiotherapist

LOS >10 days:		LOS <10 days:
86% assessed by physio	Median no. of visits = 12	Median no. of visits = 3

Types of Intervention:



Over the 3 month period, there were 724 episodes where patients were deemed unsuitable for physiotherapy due to medical instability or entering the terminal phase.

There were a further 201 episodes where physiotherapy was not offered due to a lack of staff resources.

Conclusion

Most of the patients admitted to the IPU were able to engage with physiotherapy.
The majority of patient interventions were categorised as rehabilitation, including therapeutic rehabilitation where the focus is on the person's wellbeing rather than a physical improvement.
Effective communication with the wider multidisciplinary team is a key aspect of the physiotherapy role in determining the appropriateness of intervention.

IMPLICATIONS FOR PRACTICE

Physiotherapy is a core component of specialist palliative care in the inpatient setting and must be adequately resourced to ensure holistic, patient-centred approach. The significant number of patients who engaged in physiotherapy highlights the value that inpatients place on rehabilitation, reinforcing its importance as a fundamental component of inpatient hospice care.

Using Palliative Care Outcomes Collaboration (PCOC) to measure Speech and Language Therapy outcomes

Karen Slyne, Specialist Palliative Care Speech and Language Therapist, Milford Care Centre, Limerick.

Background

The Palliative Care Outcomes Collaboration (PCOC) seeks to drive improvements in Specialist Palliative Care by using repeated assessments of the outcomes of care. To date, there is no specific outcome measurement tool for Speech and Language Therapy (SLT) in Specialist Palliative Care.

Aim

This research aimed to evaluate the effectiveness of using existing PCOC assessments to measure the impact of Speech and Language Therapy in Specialist Palliative Care.

Methods

The following assessments were used in order to measure SLT related outcomes:

RUD-ADL
to score the patient's level of functional dependence regarding eating/drinking

PSS
to score the patient's communication difficulty

SAS
to score the patient's swallow/communication levels of distress

Results

Of the 42 participants, **81%** reported a **decline in their distress** levels regarding swallowing/ communication difficulties **following SLT intervention** (Figure 1). SAS score patterns did not always correlate with severity score patterns when compared to scores attributed in the RUG-ADL and PSS .

Figure1

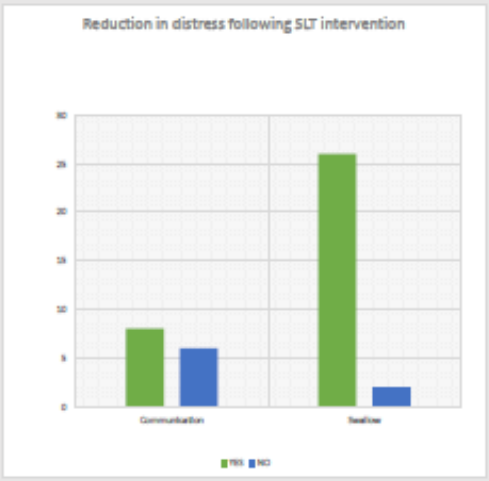
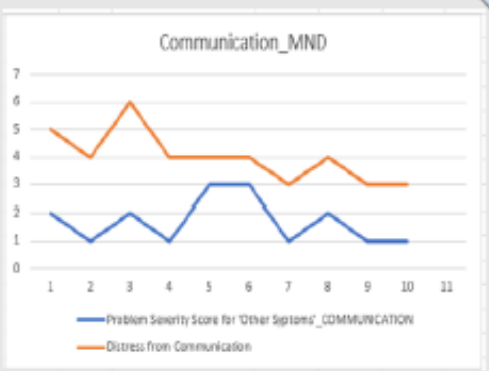


Figure 2



92% of patients with **swallowing difficulties** reported a decline in their distress following SLT intervention, while **57%** of patients with **communication difficulties** reported a decline in their distress levels following intervention (Figure 1).

Further **analysis of the data** relating to patient's with communication difficulties (Figure 2) indicated a **direct correlation between increasing/changeable levels of distress** among patients who did not receive **Augmentative and Alternative Communication (AAC) intervention** in a timely manner or for those with a **cognitive impairment** alongside their communication difficulties who have significant difficulty accessing AAC to communicate.

Conclusion

Changes relating to swallow/communication function can be effectively measured when using the PCOC RUG-ADL and PSS. However, given the deteriorative nature of life limiting illness these measures alone do not always reflect the positive impact of SLT intervention. **The results showed that SLT intervention is effective and can be reflected best when measuring levels of distress** in SPC settings in this instance by using the Symptom Assessment Scale- Other domain.

*References available on request.

Next Steps

An adapted SAS specific to SLT intervention would be preferable to effectively measure outcomes for swallow/communication intervention.

Further research should be conducted into the impact of delayed access to AAC intervention on the patient's ability to communicate and on their quality of life.

Meaningful Moments: An Occupational Therapy Group for Hospice Inpatients Facilitating Engagement in Meaningful Occupation

Niamh McKennon, Edel Cotter, Simone Sheehan

BACKGROUND

The Occupational Therapy department in Marymount University Hospital and Hospice was established in February 2022. According to the Association of Occupational Therapists Ireland (AOTI) 2025, "Occupational Therapy is a healthcare profession offering support to people with physical, psychological and social problems to enable them to live life to the fullest. Through facilitating people to engage in meaningful occupation we can enable them to live fully until they die (Hospice UK, 2015). Group occupation can promote social engagement, reduce isolation and foster peer support, while contributing to a shared goal.

METHOD

Initially a small cohort of inpatients were asked about their interests and meaningful occupations. These were then considered to inform a group activity e.g. gardening. A Plan -Do-Study - Act (PDSA) quality improvement methodology was used to guide the process of establishing the group.

Inpatients were invited to the group by their treating therapist based on clinical reasoning and consultation with the wider multi-disciplinary team.

A group protocol was devised after 6 group sessions, based on staff reflections and group observations.

Patients who are invited can bring relatives or friends to the group as desired. Occupations have included ; Baking, planting, painting, crafts, quizzes, flower pressing, mocktail making and more.

OBJECTIVES

It was identified that there was a lack of social interaction and engagement in meaningful occupation within the inpatient unit. We aimed to establish a group intervention that would address multiple perceived gaps in the service. We hoped to engage people in occupations that were important to them, establish a weekly group that would address social isolation and foster peer support. In an effort to provide interventions that are inclusive of all patients, activities are graded by the Occupational Therapist.

RESULTS

Patient feedback forms were given to patients following their attendance at the group. 100% of patients surveyed over a six month period (April-October 2024) responded 'yes' to 'Did you enjoy attending the group?'. We obtained qualitative feedback from patients and used a rating scale (1-10) to gauge their level of satisfaction with the group (see speech bubbles for a sample of these).

CONCLUSION

An Occupational Therapy group for inpatients now takes place every Tuesday morning for hospice inpatients. Patients value meeting other patients, engaging in an activity and feeling a sense of achievement in their day. We aim to continue to review the group and seek patient feedback continuously. With increased staffing we would love to offer the group twice a week.

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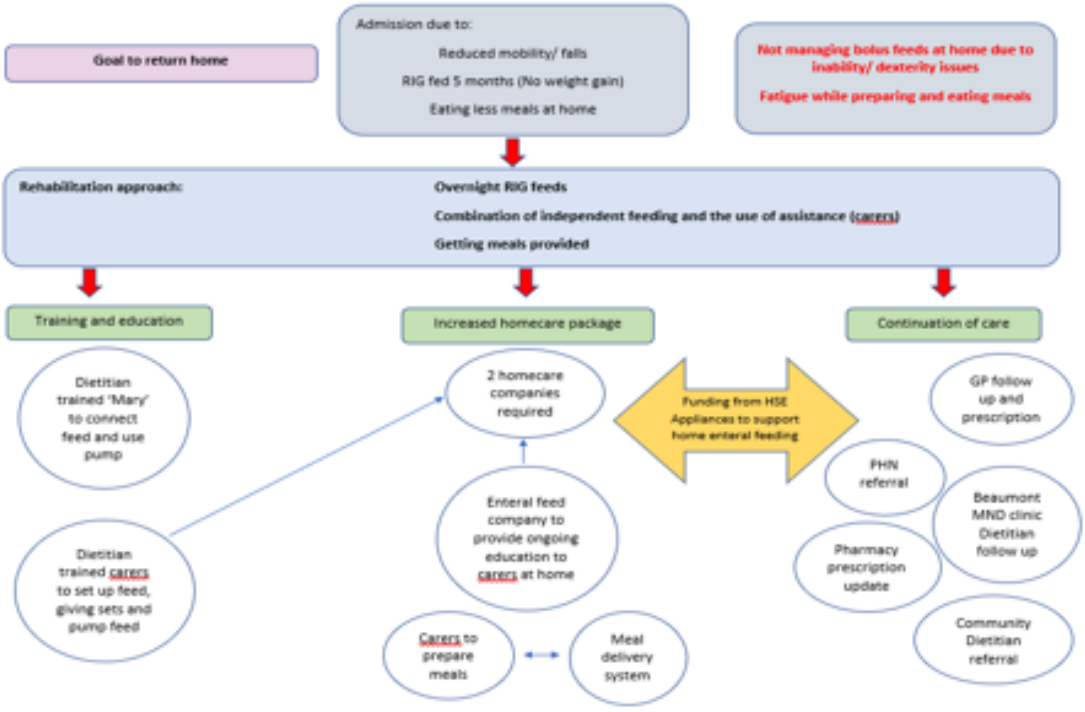
Marymount University Hospital & Hospice

Rehabilitation in a patient with Motor Neuron Disease: The Dietetic perspective. A Case Study

Marie Hannon, Our Lady's Hospice and Care Services
Harold's Cross, Dublin 6W, Ireland

Background: Motor Neuron Disease (MND) is a progressive neurological condition that attacks the motor neurons in the brain and spinal cord. This leads to weakness and muscle wasting, which can make activities of daily living challenging[1]. While early nutritional intervention at diagnosis is imperative, the continuation of nutrition intervention is vital in the context of advancing disease. Optimising nutritional status through a rehabilitative approach contributes to improved physical function to promote independence[2].



Outcomes: (within 5 week admission)

'Mary'

- went home as per her preference
- received RIG feeding to meet her nutritional requirements via a method which reduced burden on her
- had the autonomy to start her feed at a time of her choosing
- had support from trained carers
- gained 1.7kg
- had improved dietary intake for pleasure

What next?

'Mary' stayed at home for 5 months

She completed the Nursing Home Support Scheme 'Fair Deal' at home

She moved to a nursing home of her choice (from home).

Conclusion: This case highlights the importance of Dietitians working in Specialist Palliative Care to address the complex dietetic needs encountered. Dietitians are a valuable member of the team when providing palliative rehabilitation. All those who are receiving specialist palliative care should have access to an experienced dietitian.

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Multidisciplinary team (MDT) rehabilitation in integrated Palliative Care: Advanced Nurse Practitioner (ANP), Occupational Therapy (OT), Physiotherapy and Psychology working in collaboration in the Multidisciplinary Breathlessness Support Service (MBSS) to improve Quality of Life and functional outcomes for a patient with advanced Chronic Obstructive Pulmonary Disease (COPD) and anxiety.

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Our Lady's Hospice & Care Services, Harold's Cross, Dublin

Background

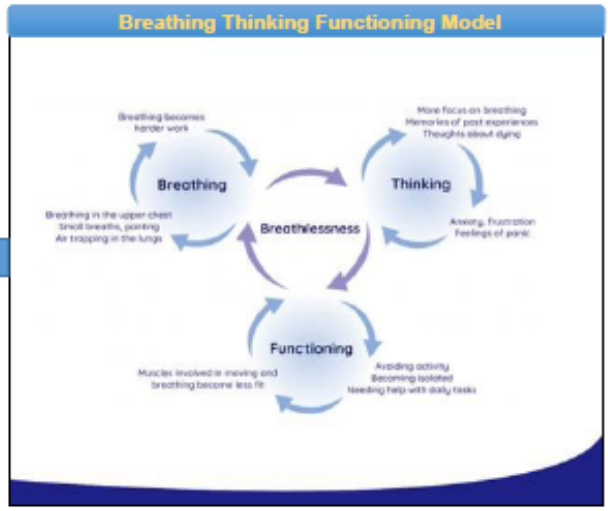
- Case study of a 67 year old lady, with a diagnosis of COPD, living in the community with severe breathlessness and anxiety.
- The patient was confined to her own home and only left to attend her medical appointments.
- The patient attended the MBSS over a period of months for MDT rehabilitation and breathlessness management.

Aim

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

Intervention

OPD appointments were co-ordinated on the same day, where possible, to reduce patient and carer burden. This also provided opportunities to apply anxiety and breathlessness management strategies in real time.



Outcome Measures

Outcome measure	PCOC SAS Scores	5XSST	SPPB	Modified Borg Dyspnoea Scale
Initial Ax	Breathlessness = 10/10	21.95 seconds	7/12	"Severely breathless"
	Fatigue = 5/10			
	Anxiety = 10/10			
Final Ax	Breathlessness = 5/10	18.75 seconds	7/12	"Slightly breathless"
	Fatigue = 0/10			
	Anxiety = 5/10			

Patient Feedback

"I can do the exercises more easily"

"I feel much more in control"

RESULTS

- The patient returned to social outings and visiting family.
- The patient complied with her prescription of medication.
- PCOC Scores for breathlessness and anxiety improved.
- Short Physical Performance Battery (SPPB) score remained stable.
- Clinically meaningful difference of >3 seconds observed in Five Times Sit-to-Stand Test (5XSST).
- The patient accepted social prescribing, e.g. onward referral to COPD Ireland.

KEY MESSAGE

- The patient demonstrated a return to community engagement, improved psychological and functional status, reduced symptoms of breathlessness, anxiety and fatigue, and her family's carer burden was alleviated following an MDT approach in rehabilitative palliative care.
- A QoL outcome measure would be a useful metric to include in future practice.

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Wicklow
Respite Rehabilitation Reassurance

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