Advanced Nurse Practitioner in Palliative care for the Older Person : Developing Communities of Care.

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St. Francis Hospice

My Role

- Advanced Nurse Practitioner for Older Person Palliative Care in a community palliative care team

- New collaboration between specialist palliative care and Medicine for the older person

- Established service in CPC Blanchardstown since 2022
- New service in CPC Raheny as of September 2026

Key Points:

- St Francis Hospice has always cared for older people.
- Greater numbers of older people are living longer with increasingly complex healthcare needs.
- Older people have different palliative care needs compared to younger people.
- The Integrated Care Programme for Older Persons (ICPOP) is developing the blueprint for new models of service provision for Older People.
- Comprehensive Geriatric Assessment (CGA) is a key building block of their work.
- There are many similarities between the CGA approach and the way that hospice services have developed their services. Hospice services began by holistically assessing care needs of their patients and building services around those needs.

Proposed Solution

- The development of an Advanced Nurse Practitioner (ANP) role focused on palliative care provision to the older person (PCOP). The ANP provides a new and additional service that meets identified need.
- By virtue of additional training, the ANP PCOP will:
- Have better knowledge of syndromes affecting older people that are not typically included in palliative care education, falls, frailty and the management of comorbidities.

What will the new service delivered by the PCOP ANP look like?

- Be accountable and responsible for advanced levels of decision-making and manage a specific patient/client caseload.
- Have an in-depth understanding of the interface between Medicine for the Elderly and Palliative Care services and have developed collaborative networks of practice with Medicine for the Elderly services in North East and West Dublin. These networks of practice will form the basis for the development and implementation of integrated patient pathways and service responses between Specialist Palliative Care, Older Persons Services and Primary Care.
- The acquisition of skills in CGA is of core importance to the role of PCOP ANP. The CGA will serve as the bridge between Palliative Care and Older Persons Care. It will enable the PCOP ANP to make an informed decision as to what services are best placed to meet the needs of the patient- Primary Care, Older Persons, Specialist Palliative Care alone or in collaboration.

The 4Ms framework

- is a core component of Age-Friendly Health Systems, designed to ensure that care for older adults is safe, effective, and aligned with their priorities.
- **Why the 4Ms Matter**
- Reduces preventable harms and improves satisfaction.
- Supports safe, reliable care across all settings.
- Helps clinicians deliver care that is both evidence-based and person-centred.

The 4Ms framework

- **What Matters**
- Identify and act on each patient's health goals and care preferences.
- Align care plans with what the patient values most in daily life.
- **Mobility**
- Maintain function and prevent complications of immobility.
- Screen for fall risk and encourage safe physical activity.

The 4Ms framework

- **Medication**
- Optimize medication use to reduce harm and burden.
- Review for inappropriate drugs, interactions, and alignment with patient goals.
- **Mentation**
- Address cognitive health, including delirium, dementia, and depression.
- Use tools such as the Mini-Cog for screening when cognition is a concern.

National Adult Palliative Care Policy Strategic objectives 2025

- Right Care
- Right place and time
- Right People
- Good Governance

CPC Early Palliative Care/ Living with Serious Illness Programme

Palliative care is often introduced earlier in the course of illness while hospital treatment is continuing. We are developing new programmes of care to meet the needs of people at different stages in their illness journey

People with advanced illness want to have as good quality of life as possible. They often prefer to spend time at home rather than in hospital. Focused , time-defined programmes of palliative care can help people to live better while continuing to receive treatment for their condition from their GP or specialist team.

Specialist palliative care inputs

- CPC CNSs
- +/- CPC consultant/ NCHD
- +/- SW
- +/- PT
- +/- OT
- +/-Chaplaincy
- ANP New evolving service

Generalist palliative care

- GP
- Primary care team
- Home Care Package
- Hospitalists and other specialists

Activities

- Educate and empower people with advanced illness to manage their health
- Support them to identify values, preferences and goals for care
- Help people with serious illness cope with symptoms and provide support to both them and their caregivers.
- Help them and their caregivers manage medications used for symptom control.
- Maximise function and independence as far as is possible
- Help with coordination of care and putting plans in place to provide care in the home setting as far as is possible.

Living with serious illness programme lens

- Communication includes use of motivational interviewing and adult learning techniques
- Identification of goals of care
- Enhanced focus on rehabilitation
- Timely transition to telehealth support or OPDS programmes or discharge from programme or end of life care supports
- Asset based approach to identification of community supports

Outcomes

- My pain and symptoms are managed
- I have the information, and support to use it, that I need to make decisions about my care
- I am as involved in discussions and decisions about my care as I want to be
- When I move between services or care settings, there is a plan in place for what happens next
- Carers report feel supported

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Key Points in Developing New Services

- Communication
- Relationships
- Skills
- Partnerships
- **Transition:** Understanding and recognising transitions of care and how they impact on the care given
- **Integration:** How palliative care is integrated into older person care is dependent on how staff understand this approach and appreciate / acknowledge its relevance in older person care.

Pathway

- Specialist Palliative care team in the acute setting to include the Mater Misericordia University Hospital (MMUH) , Connolly Hospital Blanchardstown and Beaumont hospital
- Medicine for Older Persons in MMUH Hospital, Connolly Hospital Blanchardstown and from integrated services and pathways for older people in community (ICPOP).

Referrals

- Completion of the Palliative Care National Referral Form by external referrers.

- **Patients will be identified in the following ways:**

1. at triage of CPC referrals,
2. identified by the SPOPDS (Specialist Palliative Outpatient and Day Service) team

Referrals

- 3. Identified by the hospital-based SPC team (e.g. a frail patient, for example, who may/ may not plateau and would benefit from a period of follow up or, further engagement to continue advance care planning conversations and then to see whether to stream to full-service CPC or not),
- 4. by direct referral to the ANP by Medicine for Older People , Respiratory or Heart failure team or other knowledgeable services.

Inclusion Criteria

- Patients who are ≥ 70 years, ambulant, who are referred to SFHD for symptom management or care planning with an expected prognosis of 3 months or more.
- Assess referrals for suitability on the Ambulatory Care Pathway. The ANP may provide an Out-Patient service.
- Patients may be referred to a program with the St. Francis Hospice Specialist Palliative Outpatient and Day Service team to maximize symptom management and support.
- The ANP will provide a home-based service for non-ambulant patients.

Inclusion Criteria

- Patients who are ≥ 70 years and who are attending a Medicine for the Older Person or Chronic Disease Management service and for whom a request for a joint consultation has been made by either a Consultant or ANP.
- Patients who are ≥ 70 years and under the care of SFHD community palliative care team and for whom a request for a joint consultation has been made by either a CPC Team Lead or Consultant.

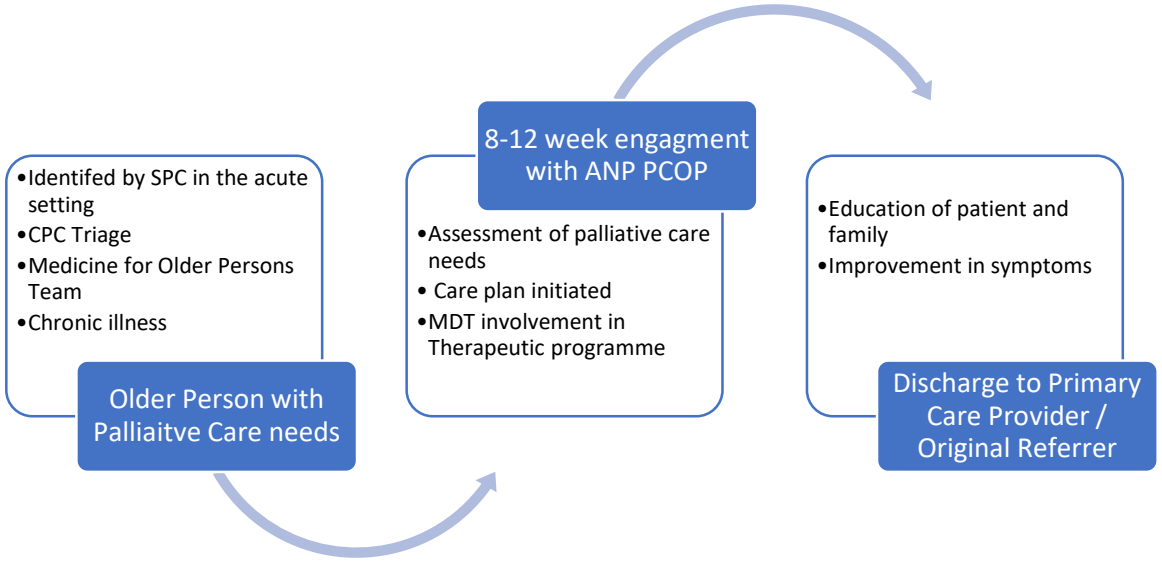
Exclusion Criteria

1. Under 70 years of Age.
2. Expected prognosis of ≤ 3 months.
3. Not living within the catchment area St Francis Hospice Blanchardstown or Raheny
4. Patients with chronic pain (rather than pain related to progressive, life-limiting disease).

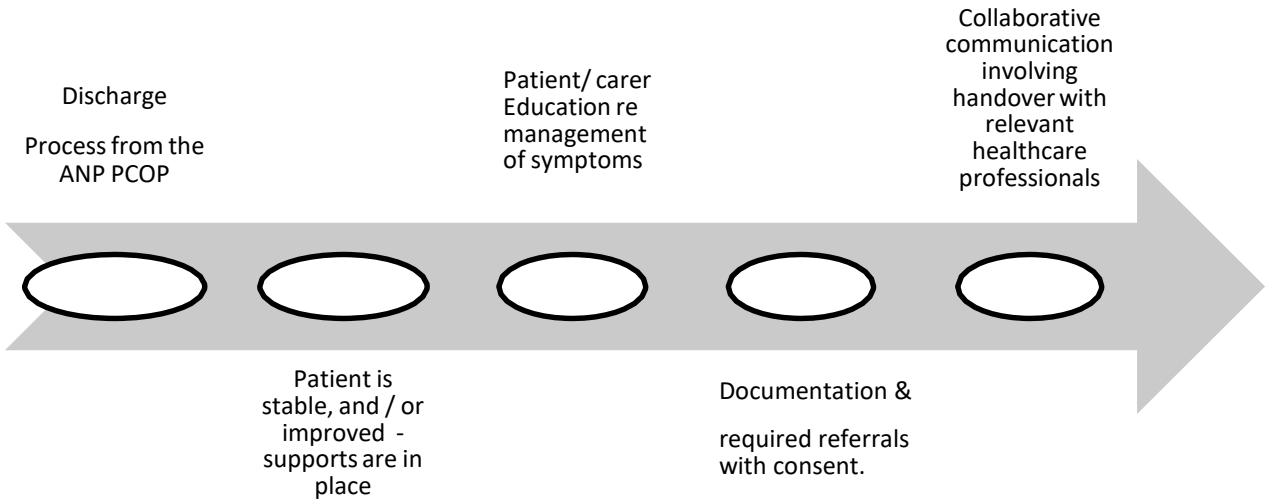
Exclusion Criteria

- 5. Patients with active substance dependency issues.
- 6. Patients with non-cognitive symptoms of dementia for whom a behavioral management and disease-modifying approach to management is indicated.
- 7. Patients who are medically unstable.

Referral Process to and from the ANP Service .



Discharge Process from ANP

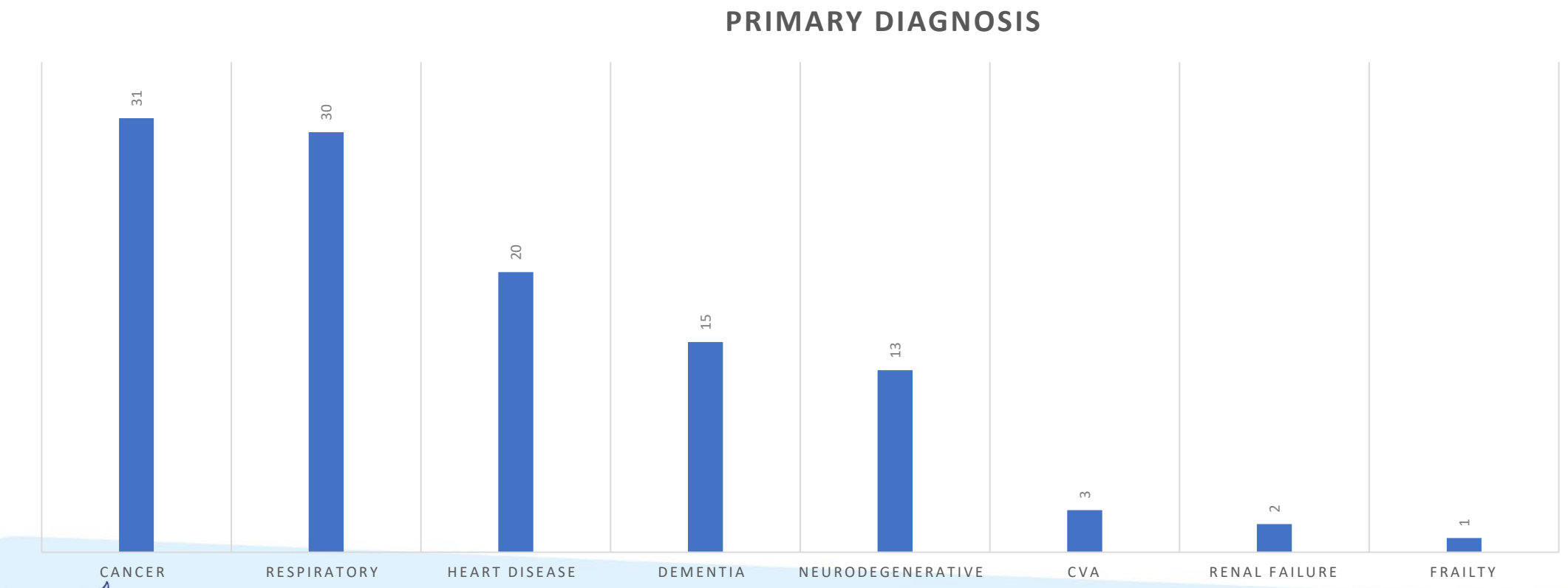


Numbers January 2025-Dec 2025

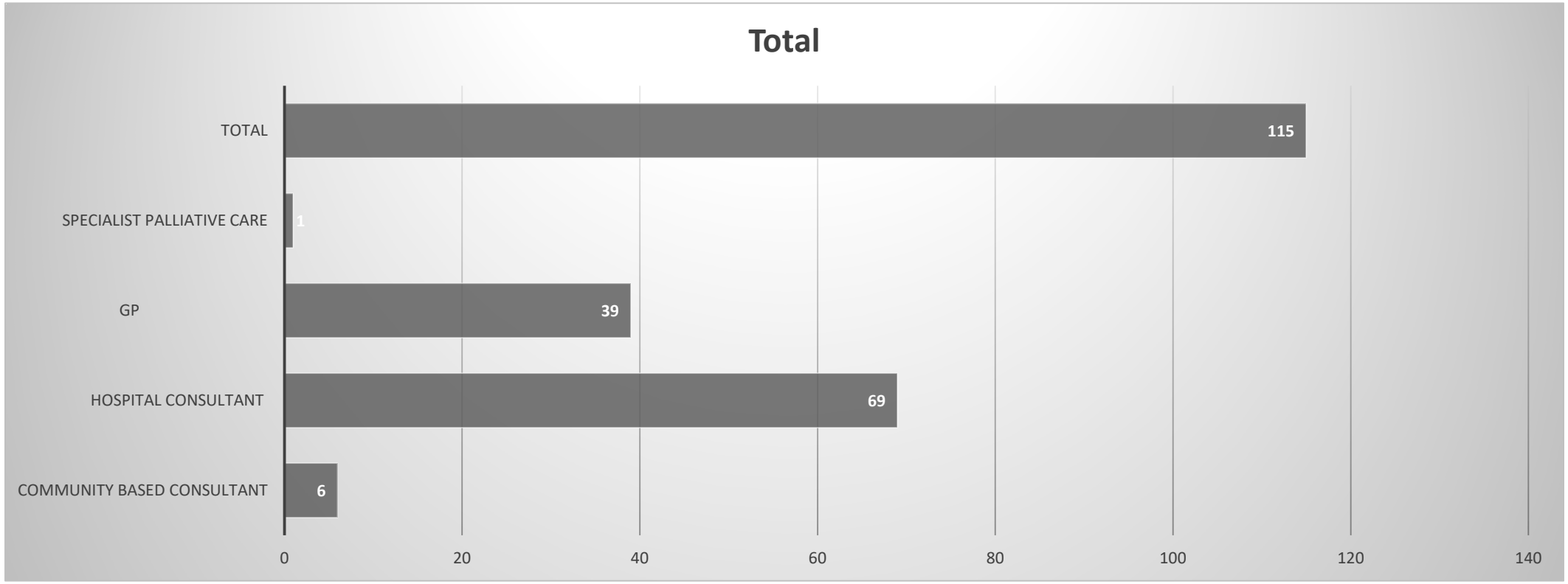
115 patients , ongoing caseload of 17-22

Min.	66.00
Max.	104.00
Median	85
Average	83.6

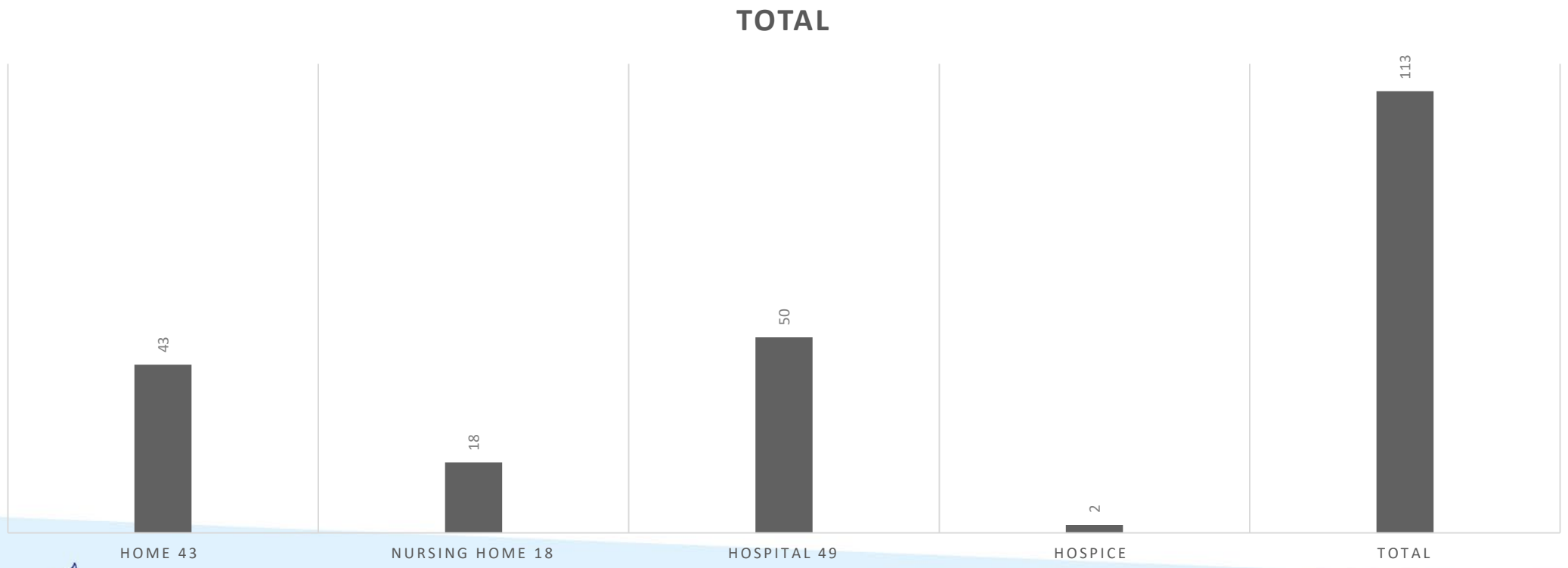
Primary Diagnosis



Referrers


Total
TOTAL
SPECIALIST PALLIATIVE CARE
GP
HOSPITAL CONSULTANT
COMMUNITY BASED CONSULTANT
115
1
39
69
6
0
20
40
60
80
100
120
140

Treatment Escalation Plan at First Assessment



Partnership with Advanced Nurse Practitioner in Medicine for the older persons

- Primarily work in Holly day hospital which is a specialist outpatient clinic for older persons with all geriatric syndromes.
- Domiciliary visits for patients known to the service (less now as integrated care team in place)
- Manage the consult service for inpatients in Connolly Hospital
- Provide an outreach service to patients known to Holly hospital who are coming towards end of life including prescribing relevant medication.
- Joint visits with both ANP in specialist palliative care and community palliative care service.

Advanced Nurse Practitioner in Medicine for the older persons

- “We really welcomed the new post of ANP in specialist care in older persons as caring for older persons at end of life can be very unpredictable”

- “We had many patients who have been referred to CPC and then discharged but also patients who deteriorated very quickly and unexpected and we had to request urgent reviews which are more difficult to co-ordinate”

- “By having an ANP service we could refer sooner which meant Una knew the patients so if they had a sudden deterioration coordinating care was much more streamlined”

Case 1AE

- 84 year old lady with, recurrent UTI's , Delirium , Dementia , Afib , CCF, severe OA , known well to Holly day hospital.
- Initially attended clinic but had become housebound
- Her overall condition had declined , referred for ACP as her desire is to be cared for at home .
- Hoist transfer
- Housebound
- HCP 4 calls a day
- Daughter her main Carer with a very close friend and neighbour calls in a few times a day .

Visit	Outcome
19/10 First Assessment , overall stable , on antibiotics for a UTI CAM negative , PPS 30 % . Bilateral leg oedema Daughter has full insight into her Mums overall condition . Discussed Comfort care measures and avoid hospitalisation	Discussed and agreed ceiling of care as oral antibiotics and comfort measures at home ; Discussed possibility of having a DNAR in the house (ongoing challenge , we sometimes use hospice letter)
09/11 Visit to A , no evidence of distress , chronic lymphedema persists but left foot and lower leg warm to touch	Contacted GP re possible cellulitis , GP agreed and I followed up with a phone call , leg was improving
01/12 Joint visit with MFOP consultant and ANP Worsening leg oedema , risk of breakdown .	Consultant started increased Burinex 2mgs BD x 5 days Discussion with team about comfort care at home . Obtained CT cream from hospice , agreed a follow up in a week .

05/12 Left leg remains red but less swollen following increase in Burinex . Awake and alert , in no distress . No evidence of Delirium	Continue Burinex MFOP review by MFOP ANP at the end of the week . I updated her daughter
14/12 Visit to A , well , stable , Eating and drinking , sitting in chair , leg remains red but stable . No evidence of delirium Daughter happy that her Mum is doing well at present .	Discussed with ANP in CH , currently no need for regular visits from Palliative care . She will follow up and contact me if she needs my input . TCU
29/12 Call from ANP to CPCT requesting urgent assistance as she visited A and there was a huge deterioration and appeared to be actively dying	CPCT CNS visited house , prepared to give A Stat for comfort as she was very weak and making groaning sounds , she died very quickly before the injection

Case 1 AE

- Co-ordinated visits between Palliative visits
- On the 29th MFOP ANP received a call from her daughter saying her mother was extremely unwell
- Home visit within an hour
- On arrival AE was extremely agitated, groaning, dyspnoeic, not responding appeared to actively dying
- Went back to hospital to get palliative meds prescribed and emailed to pharmacy
- Phoned CPC and requested urgent review
- Went to pharmacy and collected midazolam, morphine and administered stat doses
- Stayed until she settled and educated family on administering midazolam
- CPC phoned to say they would do a home visit that afternoon
- The lady died later that evening

Case 1 AE

- We both really reflected on this case it was certainly a learning for us
- There were no PRN's in the house as it was felt they were not needed however the delay that day in administering them and AE been more settled could have been prevented if they were there
- Her sudden deterioration caught us all by surprise
- We discussed timing of leaving meds in house as it can be very distressing for families having these meds and explaining them too soon on it the patients journey.

Case 2 AD

- AE 72 yr old (looked much older than her age) admitted to CHB with abdominal pain however discharged against medical advice.
- Represented 5 days later in severe abdominal pain.
- CT showed bowel obstruction with a tumour at the hepatic flexure
- Surgeons requested an urgent MFTOP review as the patient was reporting she didn't want surgery and they felt capacity was an issue
- Reviewed by MFOP team .
- Very obvious within minutes of meeting this lady she had a cognitive impairment but did not have a diagnosis
- We spent a considerable amount of time explaining to her the need for surgery
- Advised surgeons that not doing the surgery would be life threatening and therefore if AD may require some sedation pre-op
- Met family anxious +++

Case 2 AD

- Surgery went well spent 48 hours in ICU
- E reviewed her post op on ward on a number of occasions.
- When she had recovered well I moved her to one of our specialist geriatric wards for some light rehab and discharge planning
- Several family meeting held regarding prognosis and discharge planning
- When we agreed on a discharge date I phoned Una and discussed the referral
- UM kindly agreed to see her in the first week she was discharged
- I explained to family that AD would be reviewed by both myself and Una on discharge
- Family stress ++++++

Case 2 AD

- Phone call from E re lady she was referring
- Referral sent in on 26/10/25
- Discussed with UM ANP for joint home medel visits
- Admitted to CH with Ab pain
- CT scan : Large Bowel obstruction with focal mural thickening and luminal narrowing at hepatic flexure
- Liver Metastases 2.5cm lesion
- History of Dementia , officially diagnosed on admission to hospital but family report changes in her memory for a while

Case 2 AD

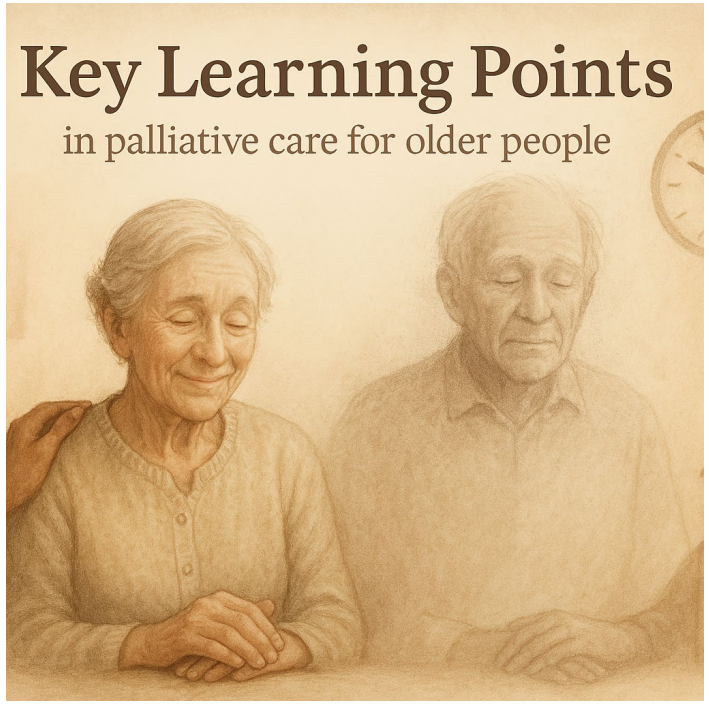
- First visit 28/10/2025
- Pain main symptom , lower back
- High levels of distress
- Suggested low dose of oxynorm 1mg 4 hourly PRN

VISIT / PC	OUTCOME
31/10/25 PC from PHN Ann very confused and agitated ? Pain	Start the Oxynorm Liquid 1mg 2-3 times a day
03/11/25 Visit high stress levels , escalation of symptoms of dementia .Fall at night Grandson coming from Oz	Increase in HCP to QDS , total of 5 hours . Diazepam at night 5mgs Referral to Pastoral Care (visited x 4 times at home)
06/11/25 Joint visit with ED MFOP Main issues related to restlessness and agitation in the evenings	Quetiapine 12.5mgs at 3pm with additonal dose at night time .Discussed Butrans Patch
10/11/2025 Joint visit with ED	Increased Oxynorm to 2mgs 2-4 hourly . Agitation settled with Q
17/11/2025 S/B ED , Butrans Patch started . Anger increasing , lashing out at family .	ED suggests increase of Quietiapine to 25mgs at night . Family keen for admission , I felt it was too soon , stable condition (challenge to prognosticate in dementia care)
25/11/2025 High level of stress in house ,objectively Ann very comfortable Family feel she is in pain . Psycho social issues	Increase quetiapine 12.5mgs BD and 25mgs at night . Get Alprazolam .125mgs (long hx of benzo use in the past)

Visit /PC	Outcome
PC 26/11/2025 suggested a night nurse to monitor situation overnight	Left NNL letter and meds in house then her husband declined offer of help at night
01/12/2025 Visit Ann very comfortable , daughter extremely stressed .	
03/12/25 Chaplaincy visit A lot of existential distress	Support and prayer
03/12/25 CPC visit call from daughter re overall decline	No new changes , re assured
09/12/2025 Joint visit ED and UM Increased frailty , weight loss , deteriorating , listed for IPU	Admitted 10/12/2025 RIP21/12/2025

Key Learning Points

- Frail Older People live longer than you expect
- They also die more quickly than you thought
- Highlights the importance of shared knowledge
- Joint working interfaces
- Advance care planning , realistic goals



Support of professionals / Joint visits

Brian Magennis ANP MFOP MMUH	Elaine Dunne ANP MFOP CH	Elaine Craven ANP Respiratory CH	Shirley Long CNS MFOP ICT	Tracy Keating ANP CMOP
Amanda Wilkinson ANP Psychiatry Older People	Denis Saric ANP MFOP now FIT CH	Joseph Duran CNS CMOP , now cANP CH	Pam Cryan –Quinn CNS Respiratory ICT	Lynn Fox ANP ILD MMUH
		Caroline Smyth ANP Oncology MMUH		

Possible points for consideration

- Activity levels- balancing caseload and ability to respond to urgent requests; casemix- ensuring referrals that are being seen by PC ANP service are matched to need
- Responsiveness
- Medication management
- Current development of Out Patient and Day Services (OPDS) is ongoing- dynamic and evolving situation
- DNACPR order documentation or other treatment escalation planning documentation/Message in a bottle

Coming together is a beginning.
Keeping together is progress.
Working together is success.

(Henry Ford)

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