Rehabilitation in Life Limiting Conditions

Leah Raggett Senior Physiotherapist in Oncology
Caoilfhionn O'Donovan Senior Occupational Therapist in Oncology

Palliative Care Study Day 2026

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Definitions

What is **Rehabilitation**?

'A set of interventions designed to **optimise functioning** and **reduce disability** in individuals with health conditions in interaction with their environment' (WHO 2024).

What is **Palliative Care**?

'Palliative care is an approach that **improves the quality of life** of patients and their families, who are facing challenges associated with life-threatening illness, whether **physical, psychological, social or spiritual**' (WHO 2018).

When Did The Two Fields Start to Come Together ?

Dame Cicely Saunders, founder of the modern hospice:

'You matter because you are you, and you matter to the last moment of your life. We will do all we can not only to help you die peacefully, but also **to live until you die**.'

1969 Dietz	4 stages:	1993 Hockley
• **Cancer Rehab Model**: bringing forward a connection between rehab and palliative care.	• **Preventative** • **Restorative** • **Supportive** • **Palliative**	• Challenges the traditional division between rehabilitation and palliative care.

Both palliative care and rehab share essential characteristics, they are symptom-oriented approaches that focus on function and comfort with a holistic framework.
The overarching goal is quality of life (Timm, Thuesen and Clark, 2021).

Rehabilitative Palliative Care

A **person-centred** approach that integrates rehab principles into palliative and end-of-life care. It emphasises **interdisciplinary care** and support for comfort, coping, and adaptation to life-limiting illness. It aims to **preserve dignity, autonomy** and **quality of life** at all stages of illness (AIIHPC 2025).

HSE National Adult Palliative Care Policy Implementation Plan

2025 - 2026

Palliative Care Competence Framework

MEDICINE | NURSING | MIDWIFERY | HEALTH CARE ASSISTANTS

SOCIAL WORK | OCCUPATIONAL THERAPY | PHYSIOTHERAPY

SPEECH AND LANGUAGE THERAPY | DIETETICS / CLINICAL NUTRITION

PHARMACY | PSYCHOLOGY | CHAPLAINCY/PASTORAL CARE

Feidhmeannacht na Seirbhíse Sláinte Health Service Executive

PALLIATIVE CARE

Tús Áite do Shábháilteacht Othair 1 Patient Safety First

FORUM OF IRISH POSTGRADUATE MEDICAL TRAINING BODIES

All Ireland Position Paper on Rehabilitative Palliative Care

Green Paper: November 2025

AIIHPC All Ireland Institute of Hospice and Palliative Care

HSE

HSC Public Health Agency

RCSI Faculty of Nursing and Midwifery

Principles of Rehabilitation in Palliative Care

Person Centred

What matters to the person?

The goal is not simply to improve function. It is to improve the person's quality of life (Pryde et al., 2026)

Person-centred care is strongly supported as a care philosophy, but the direct causal evidence that specific person-centred rehabilitation processes improve every outcome remains limited (Yun et al., 2019)

Palliative rehabilitation and quality of life: systematic review and meta-analysis (2026)

Goal Orientated and Meaningful

Function is a means to participation

Goals should be meaningful to the individual, rather than determined only by clinical measures

Patients goals are often under represented (Brose et al., 2023)

Optimise Function, Autonomy and Participation

Enable people to do what they can

Rehabilitation aims to preserve ability, support autonomy and reduce unnecessary dependence

- Capacity – activity – participation

- WHO, 2023; Manson et al., 2025

Proactive but Proportionate, Flexible and Changing Goals

Rehabilitation should be offered early and adapted over time depending on the persons needs

Do not wait until all function is lost, but do not impose rehabilitation that creates more burden than benefit.

Restoration → maintenance → adaptation → comfort

WHO, 2024

Inter Disciplinary and Enabling

Holistic Approach

Physical: pain, fatigue, breathlessness, weakness, mobility, balance, nutrition

Cognitive: attention, memory, information processing, problem solving

Psychological: anxiety, depression, fear, decreased confidence, adjustment to changing function

Social: roles, relationships, social participation, carer needs

Spiritual/existential: hope, meaning, identity, personal values, concerns about dying

(Tiberni and Richardson, 2015)

Interventions

Function

Core Role of Physio and OT is looking functional status

Mobility and **Activities of Daily Living**

Goals are centred around function, quality of life and participation

Physical Activity/Exercise

Aim to engage in physical activity according to the person's ability.

Aerobic and resistance components

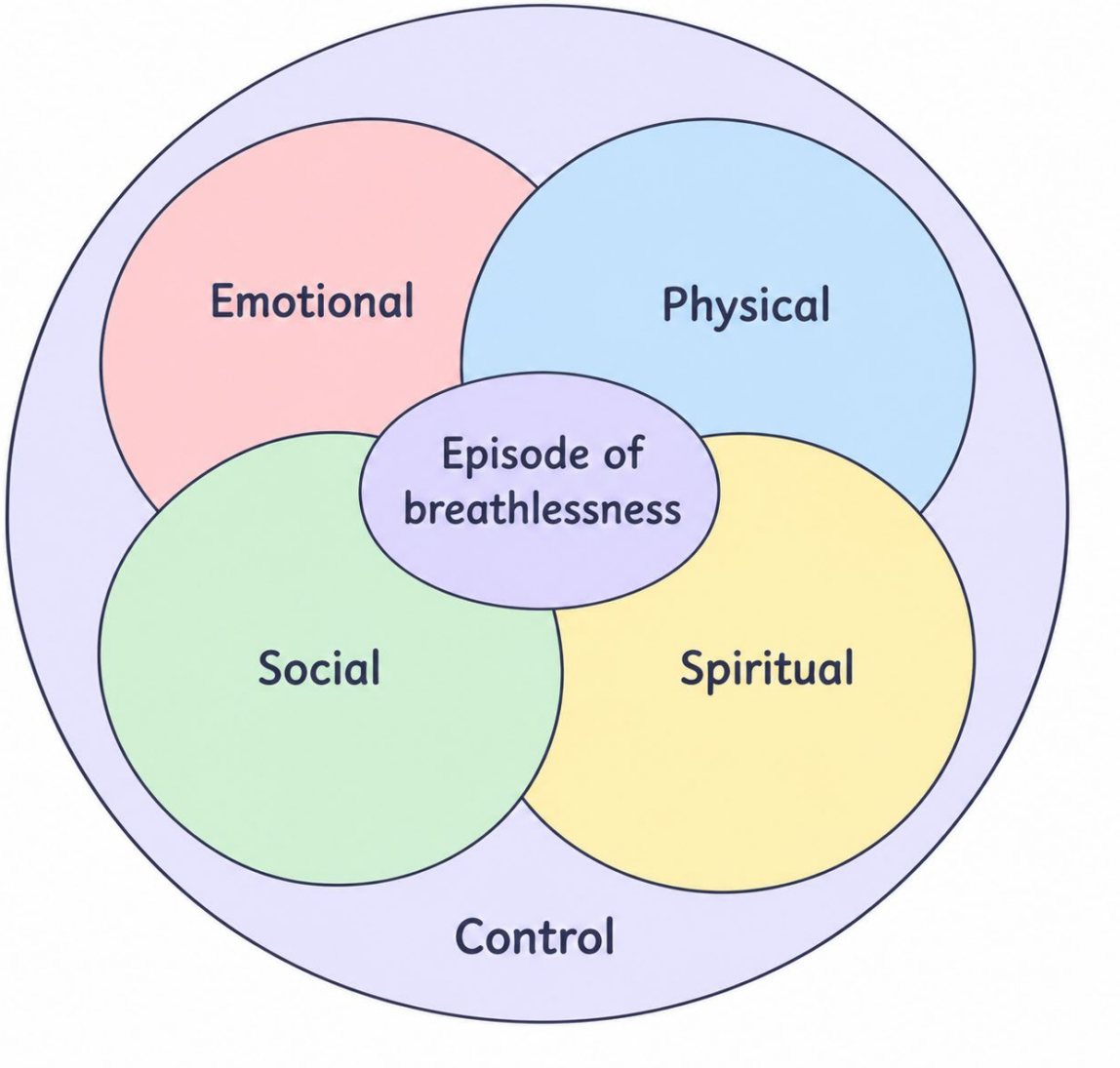
Walking programme, muscle strengthening and flexibility

Individualised, goal-oriented, patient led.

Shown to improve mobility outcomes in advanced cancer Petrasso et al., 2024

Breathlessness

- Breathlessness can be **multifactorial** and **complex**.
- Physiological measures are only weakly associated with a patient's experience of breathlessness.



(Crombeen and Lilly, 2020)

Breathlessness Management

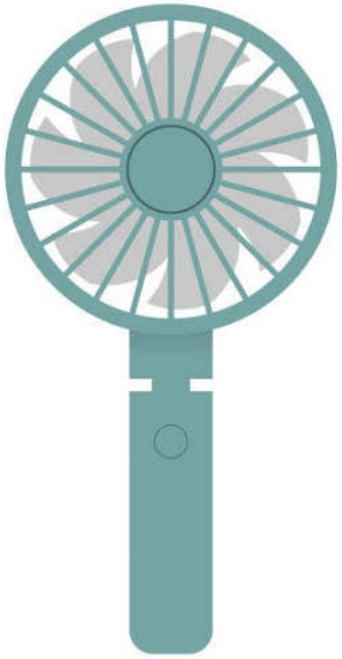
<u>European Respiratory Society Clinical Guidelines: Holland et. Al 2024</u>

Supplementary oxygen

Breathing techniques:

Pursed lip breathing

Diaphragmatic breathing



Fan Therapy

Sleep

- Important for those navigating life limiting conditions
- Critical role in healing, cognitive function, emotional well-being
- Consistent, restorative sleep can be challenging
- Medications can impact sleep
- Lack of sleep can impact symptoms
- Can impact cognition, decision making

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Sleep Hygiene Tips

ROUTINE-SET WAKING & SLEEP TIMES

COMFORTABLE ROOM- QUIET, DIM LIGHTING, COOL TEMPERATURE

LOOSE, SOFT CLOTHING

AVOID DRINKING A LOT BEFORE BEDTIME

AVOID HEAVY, SPICY, SUGARY FOODS, CAFFEINE

STAY ACTIVE DURING DAY, AVOID EXERCISE 3 HOURS BEFORE BED

AVOID TV, SCREENS IN BEDROOM

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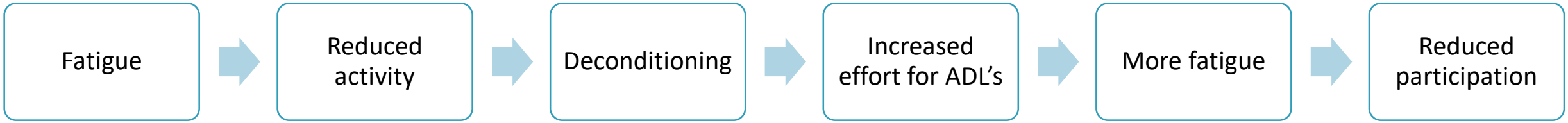
What Does Fatigue Mean for the Person ?



Physical fatigue

- Body exhausted
- Symptoms increased
- Heavy legs
- Shaking hands

Cognitive/mental fatigue

- Brain fog
- Difficulty concentrating
- Difficulty making decisions
- Word finding difficulties
- Slow reactions

Emotional fatigue

- Anxiety
- Stress
- Lability
- Feeling numb

Considerations

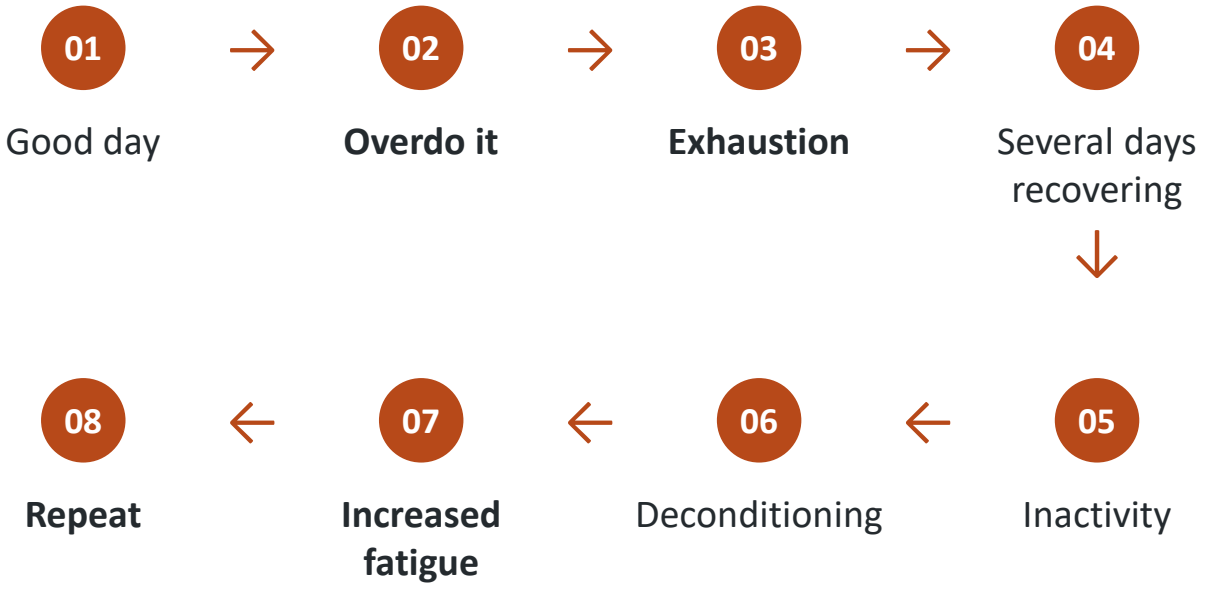
(Bower et al., 2024; Agbejule et al. 2022; Shimiziu et al., 2026; Kim et al., 2022)

Energy Conservation

Plan	Organise activities around energy levels, schedule rest breaks
Prioritise	Identify important activities and necessary. Remove less important tasks
Pace	Break down activities and alternate with rest
Position	Consider body positions
Permission	Permission to do things differently, ask for help

Consistency Breaks the Boom-and-Bust Cycle

THE BOOM–BUST CYCLE



A BETTER RHYTHM

Build recovery into the plan — not after exhaustion.

01 **Activity**

02 **Planned recovery**

03 **Activity**

04 **Maintain consistency**

Aim for repeatable activity,
not maximum activity on a good day.

Person, Environment and Occupation Shape Performance

ACTIVITY MODIFICATION

START HERE

Identify the difficulty → modify.

Adaptive equipment can optimise function and participation

ADAPTIVE EQUIPMENT

Problem	Possible intervention
Difficulty walking	Stick/frame/rollator/wheelchair
Breathlessness standing	Perching stool
Difficulty showering	Shower chair
Difficulty getting off toilet	Raised toilet seat/rails
Difficulty bending	Long-handled aids
Reduced hand function	Built-up handles/adapted utensils
Fatigue carrying objects	Trolley/bag with wheels
Difficulty reaching	Reacher
Reduced independence outdoors	Wheelchair/scooter where appropriate
Difficulty transferring	Transfer aids/appropriate seating
Difficulty maintaining position	Cushions/positioning equipment

Source: Morgan et al. (2022)

Positioning supports comfort, pressure care and safe movement

POSITIONING • PRESSURE CARE • TRANSFERS

01 COMFORT & SUPPORT

— Comfortable positioning in bed/chair

— Supported limbs

— Appropriate cushions

— Bed positioning

02 PRESSURE & MOVEMENT

— Pressure redistribution

— Contracture prevention

— Seating assessment

— Transfers

03 SYMPTOMS & CARE

— Positioning for breathlessness

— Positioning for pain

— Maintaining comfort during personal care

Consider the person’s comfort, skin, movement and symptoms together.

Caregiver Education

- Safe transfers
- Mobility assistance
- Equipment
- Positioning
- **When to assist vs allow independence**
- Conserving the person's energy
- Safe use of walking aids
- Recognising deterioration
- Avoiding unnecessary physical strain on carers
- **How to support rather than take over**

To Summarise: Rehabilitation Throughout

Earlier in Illness	Progressive Illness	Advanced/End of Life
Strength & endurance	Maintain function	Comfort
Exercise	Pacing	Positioning
Mobility	Adaptive equipment	Supportive equipment
Independence	Compensation	Assistance
Prevent deconditioning	Energy conservation	Energy preservation
Participation	Meaningful activity	Meaningful moments
Restore/maintain	Adapt	Comfort/dignity

Challenges

- **Changing goals**
- **Time and prognosis**
- **Fluctuating function**
- **Patient and family expectations**
- **Balancing benefit and burden**
- **Emotional impact**
- **Risk versus participation**
- **Changing rehabilitation goals over the illness trajectory**

Patient & Family Expectations

Exploring expectations, hopes and what mattters most

EXPECT

Patients and families may hope that rehabilitation will:

- “Will I walk again?”
- “Can I get back to normal?”
- “Can rehabilitation stop me getting worse?”

EXPLORE

Have open, honest conversations to understand what the goal really means for the individual.

- What would that enable you to do?’
- What matters most to you?’
- Explore hopes, fears and preferences.

ADAPT

Develop realistic, meaningful and flexible goals, tailored to the person’s changing needs.

- Focus on what matters most.
- Use a range of strategies and supports.
- Review and adapt as the condition changes.

**Rehabilitation is *not* about taking away hope –
it is about connecting hope to what matters.**


Case Study

Una

41 year old female presented to local hospital with 3/52 history of severe headache.

CT Brain in ED showed **right frontal** space occupying lesion.

Transferred to Beaumont for neurosurgical intervention:

Craniotomy for **resection** and **biopsy** of right frontal lesion.

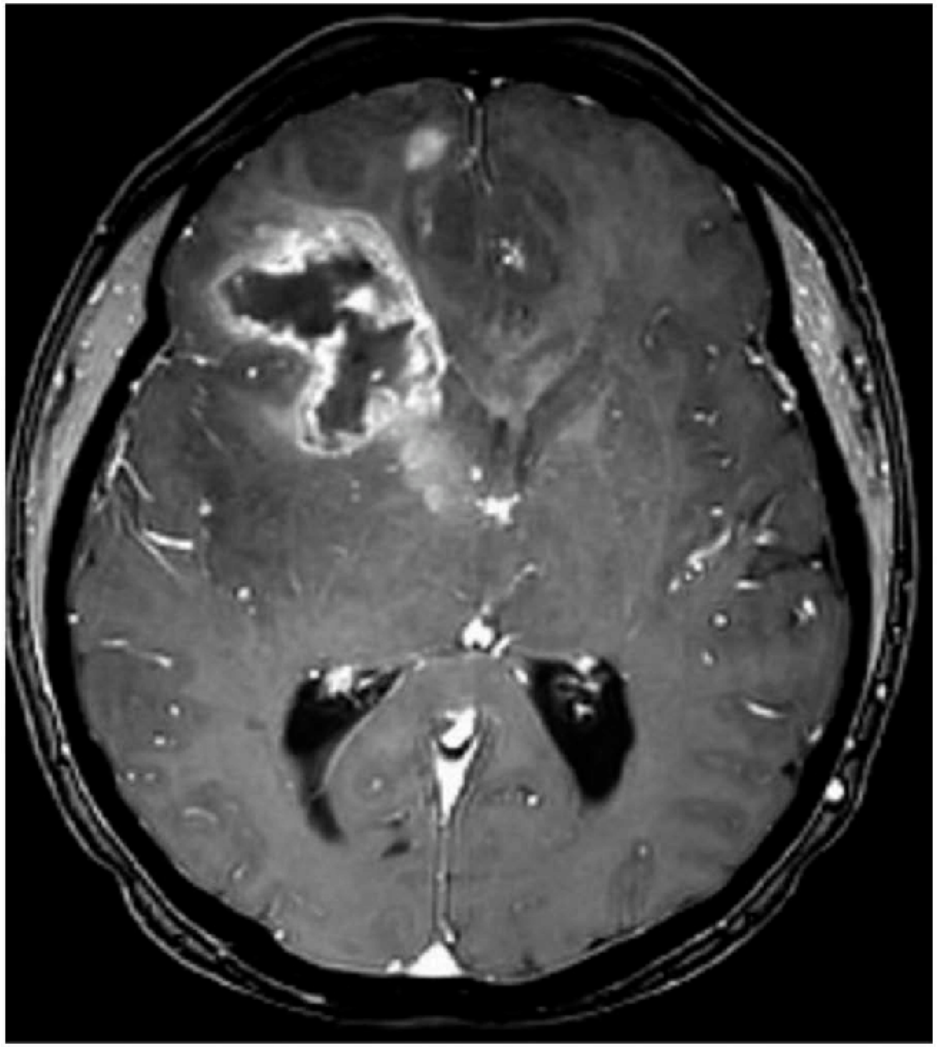
MRI Brain Report: Peripherally solid enhancing, centrally cystic mass in the **right** parasagittal **frontal lobe.**

Most likely primary high grade neoplasm.

Diagnosis: **Glioblastoma Multiforme**: Grade 4 Brain Tumour

- Poor Prognosis

Life-limiting Condition

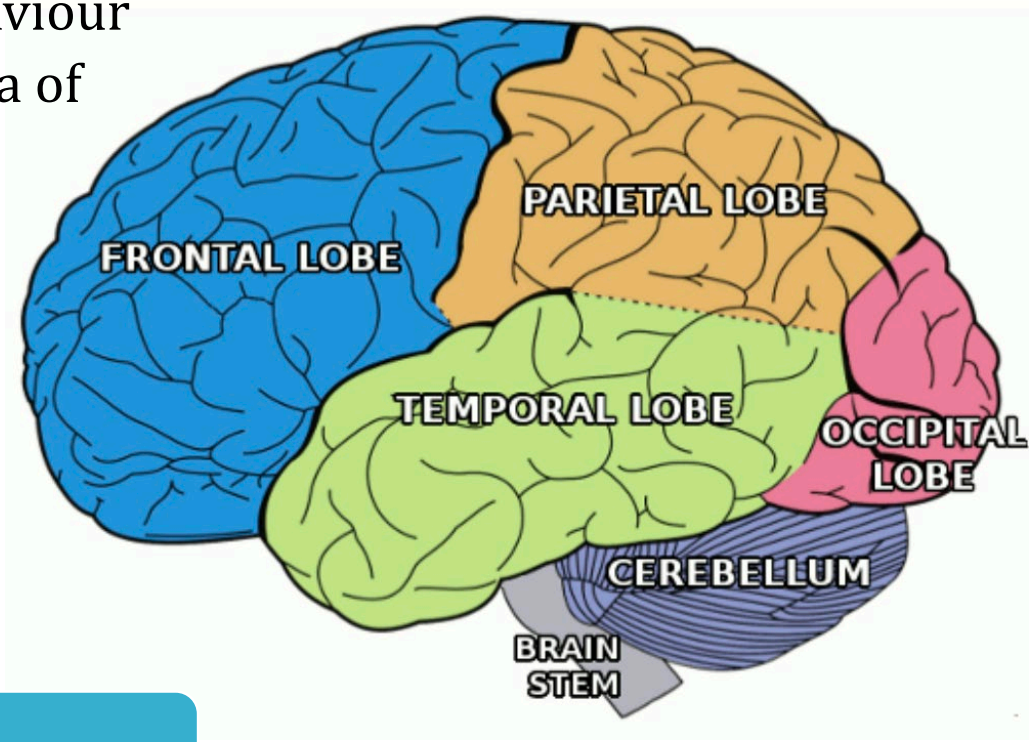


T 1 -weighted axial image (Shukla et al., 2017)

Anatomy of the Brain

Frontal Lobe Functions:

- Voluntary motor activity and initiating motor behaviour
- Expressive or motor aspect of language (Broca area of dominant hemisphere)
- Emotions
- Motivation
- Personality
- Initiative
- Judgement
- Ability to concentrate
- Social inhibitions



(Krebs, 2011)

Initial Assessment

- Admitted to ICU post-op for 3/52.
  - Focus on prevention of respiratory complications.
  - Provided with high support wheelchair: full hoist ass x 2 transfer.
- Transfer to Ward
  - Bed mobility: Ass x 2
  - Sitting balance: Ass x 1
  - Full hoist ass x 2 to high support chair

Power Ax	Right	Left
Upper Limb	5/5	5/5
Hip Flexion	3/5	3/5
Knee Flexion	3/5	3/5
Knee Extension	3/5	4/5
Dorsiflexion	3/5	3/5

What Matters to Una?

Exercising weekly

Make-up and hair care

Cooking meals for children

Walking with husband

Restoration Phase

Neurosurgery Team: Early Stage of Rehab

Main focus: Sitting balance and transfers.

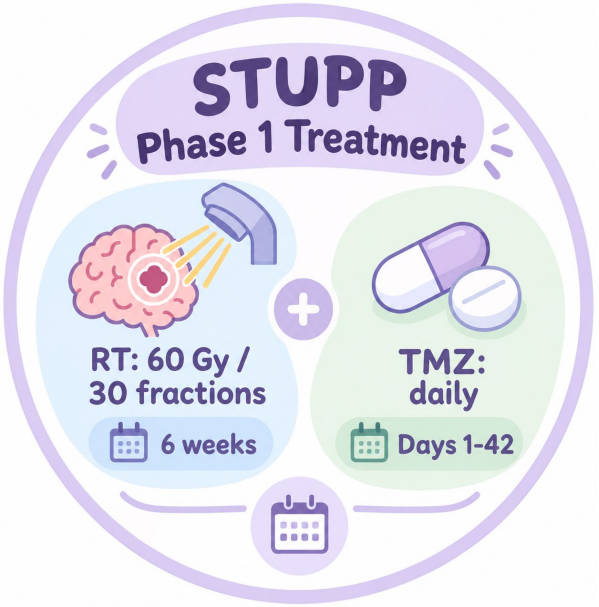
Short Term Goals:

- Sitting out daily
- Progression to sara steady
- Applying makeup assist of 1

Treatment:

1. Sitting balance re-education: dynamic actvities.
2. Transfer practise with sara steady.
3. Work on initiating a stand
4. Cognitive stimulation strategies and meaningful activities: orientation board, make-up, colouring, listening to music
5. Motomed, lower limb

Restoration Adaptation



After 2 months take over of care by **Radiation Oncology** to start Rx.

Due to high level of care needs, remained inpatient for radiation

- Considerations: Side effects of radiation: Fatigue, Reduced exercise tolerance.
- Solution: Shorter sessions, rest time factored into the day

Goals:

1. Mobilise to toilet on ward ass x 1
2. Upper body dressing
3. Ind application of makeup

Treatment:

1. Standing endurance work with table top activities with upper limb.
2. Functional mobility
3. DADL practise

Adaptative Supportive

Main focus: Planning for home.

- Community OT: Home adaptations, particularly in bathroom
- Community PT: for maintenance of mobility
- Total inpatient stay: 4 months.
- Ongoing outpatient Chemotherapy

Current Function:

- Ind mobile with walking stick.
- Provided with 4 wheel walker for outdoors.
- Ind showering with adaptive equipment.
- Ind with PADLs
- Ind preparation of breakfast for kids.

Re-Admission: Palliative Approach

- Admitted to hospital after 12 months at home.
- Decline over previous 6 weeks:
  - Changes to cognition, behaviour
  - Decreased mobility
  - Dragging left foot.
- Struggling to manage at home.

Progression of disease on MRI Brain

Goals of rehab are on **participation, comfort and engagement** rather than restoration.

What Matters to Una?

Makeup application daily

Toileting in private

Spending time with children

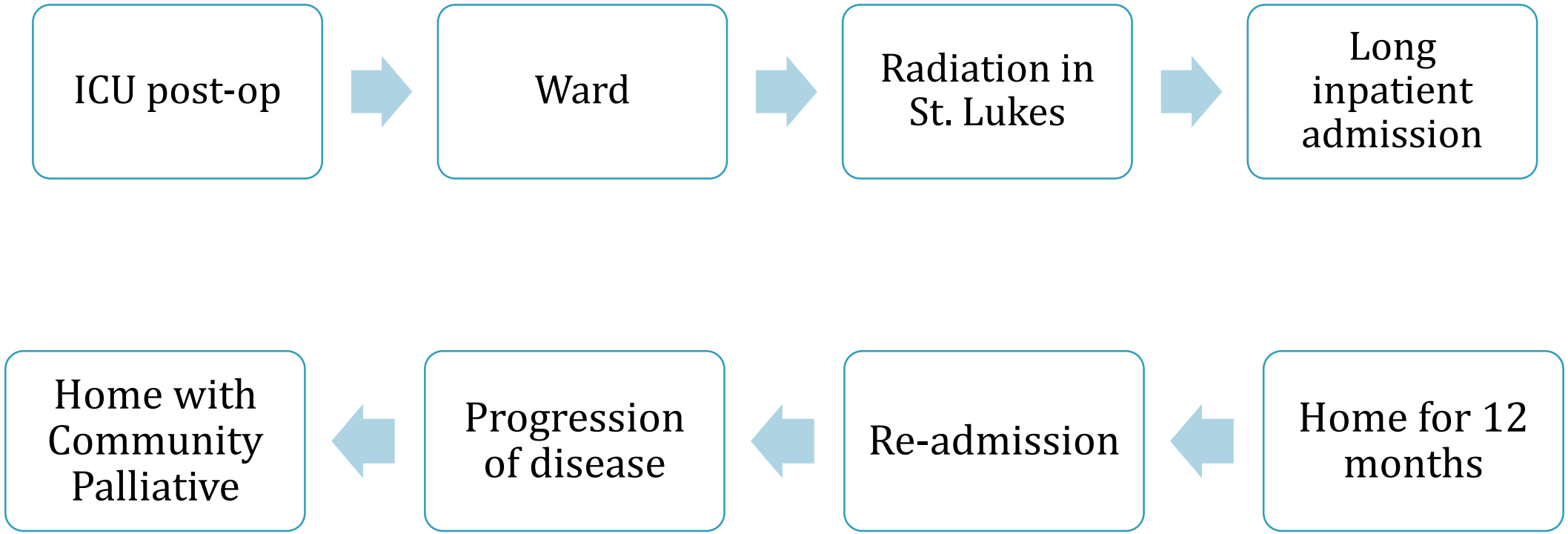
Watching TV with husband

Palliative Approach

Approaching End of Life

Spend Time with Children	Toileting in Private	Makeup Appplication Daily
• One child has autism, unable to come to ward. • Provided with wheelchair to faciltate transfer to garden	• Focus on mobility • Provided with dictus splint and frame • Sara steady for back-up	• Assistance with set up. • Upper limb programme

Rehabilitation Throughout Journey with Life-Limiting Condition



As disease progressed, goals of rehabilitation changed.

Thank you for Listening

Any questions ?

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